

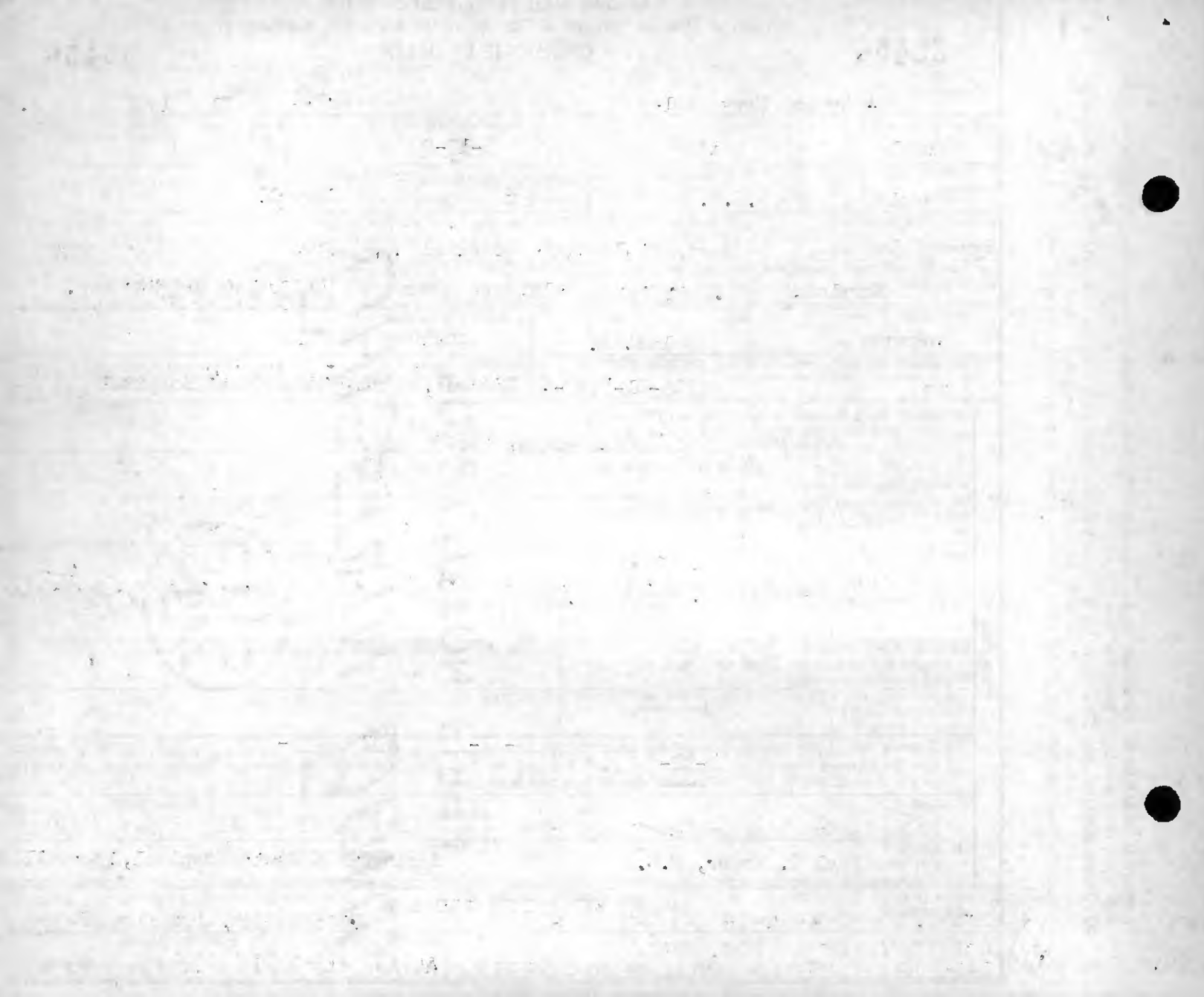
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Gertrude Mary Adler | | | 2a. DATE OF DEATH Month Day Year April 11 1968 | | 2b. HOUR 6 A.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 1-5-90 | | 6. AGE (In years last birthday) 78 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Russia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Carroll Md. | | |
| 10. CITY OR TOWN OF DEATH Sykesville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 7204 CAMPFIELD ROAD #7 | |
| 14. FATHER'S NAME First Middle Last unknown Applestein | | 15. MOTHER'S MAIDEN NAME First Middle Last XXXXXX ESTHER ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16b. SOCIAL SECURITY NO. 215-01-8799-A | 17. INFORMANT MR. RUBEN ADLER, 7204 CAMPFIELD ROAD, BALTIMORE, MARYLAND 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 492X | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-OR-CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome associated w/ senile brain changes & psychosis. | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-11- , 1967 , to 4-11 , 1968 , that (I) (we) last saw the deceased alive on 4-11- , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Paul G. Ensor, M.D. | | DEGREE M.D. | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 11 April 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M.D. | | 22e. ADDRESS Springfield State Hospital, Sykesville | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 4-12-68 | 23c. NAME OF CEMETERY OR CREMATORY OUR KNESSETH ISRAEL ANSHE SFARD | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. | | 25a. REC'D BY REGISTRAR DATE APR 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| 6010 REISTERSTOWN ROAD, BALTO. 21215 | | | | | |



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) HARLAN KEETER ALBAUGH | | | | | | 2a. DATE OF DEATH Month 4 Day 14 Year 68 | | | 2b. HOUR 5:30 M | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH June 17, 1893 | | 6. AGE (In years last birthday) 74 YRS. | | IF UNDER 1 YEAR MONTHS 7 DAYS 14 | | IF UNDER 24 HRS. HOURS 5 MIN. 30 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Westminster | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. General Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maintenance | | | 12b. KIND OF BUSINESS OR INDUSTRY State Hosp. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Sykesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Rt. 3, Box 344 | | | |
| 14. FATHER'S NAME First Charles I. Middle Albaugh Last Albaugh | | | | 15. MOTHER'S MAIDEN NAME First Emma Middle Stollman Last Stollman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 219-36-2175A | | 17. INFORMANT Address Mrs. Mary E. Albaugh, Sykesville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4 10.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION, MASSIVE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 WKS. YEARS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22, 1968 , to 4/14, 1968 , that (I) (we) last saw the deceased alive on 4/14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Vincent J. Brown Jr. M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/14/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/18/68 | | 23c. NAME OF CEMETERY OR CREMATORY New Freedom Cem. | | 23d. LOCATION (City or Town) (County) (State) Liberty Rd. Carroll Md. | | | | | |
| 24. FUNERAL DIRECTOR H. C. Barton, Walkersville, Md. 21793 | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |
| DATE APR 18 1968 | | | | | | | | | | | |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) Samuel | | | First Ebenezer | | | Middle Allen | | | Last | | | 2a. DATE OF DEATH April 4, 1968 Day Year | | | 2b. HOUR 8:25PM | | |
| 3. SEX Male | | | 4. RACE Negro | | | 5. DATE OF BIRTH 9/18/70 | | | 6. AGE (In years last birthday) 97 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Jamaica | | | 7b. CITIZEN OF WHAT COUNTRY? Unknown | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Carroll County, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Balto. City Baltimore | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 2200 Druid Hill Avenue | | | | | |
| 14. FATHER'S NAME Unknown | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME Unknown | | | First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 214-56-9729 | | | 17. INFORMANT Records, Springfield State Hospital | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Terminal bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Days | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13/68 , 19__, to 4/4/68 , 19__, that (I) (we) last saw the deceased alive on 4/4/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22b. SIGNATURE Octavio A. Ruiz DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED 4-9-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D. | | | 22e. ADDRESS Springfield State Hospital | | | | | | | | | | | | | | |
| 23a. BURIAL-CREATION, REMOVAL (Specify) | | | 23b. DATE 4-11-68 | | | 23c. NAME OF CEMETERY OR CREMATOR St. Mary's Med. School | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Howell Funeral Home | | | ADDRESS Baltimore, Md. | | | 25a. REC'D BY REGISTRAR APR 17 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |

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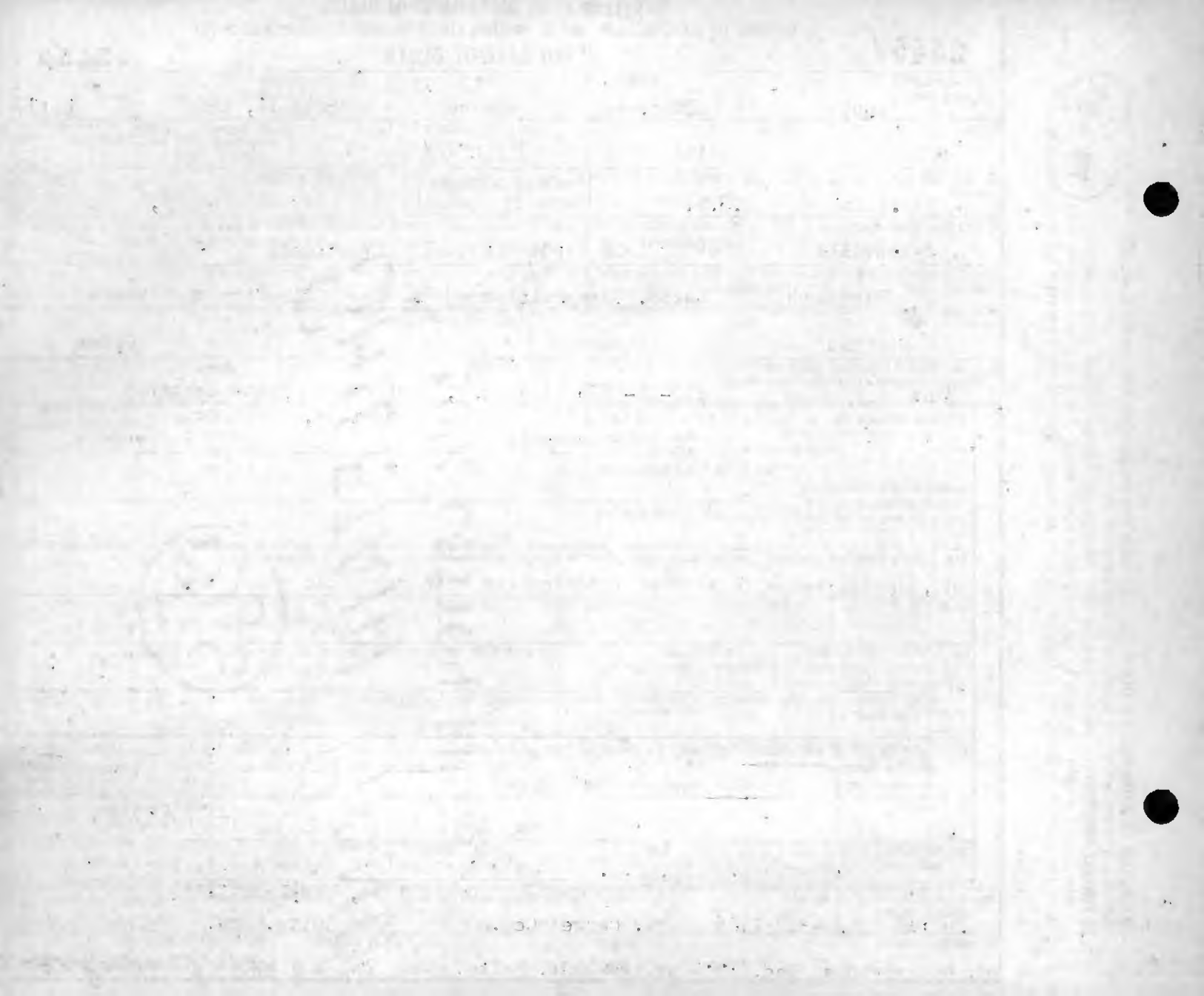
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VR 4-1-64
304M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--------------------------|---|---|---|--|--|-------------------|
| 05453 CERTIFICATE OF DEATH 05459 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Louis | | | Dinerway | Almond | April 16, 1968 | | | 11:30 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | White | | 10/22/99 | | 68 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Carroll County, Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Sykesville | | Springfield State Hospital | | | | (Retired) | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | Balto. | | City Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2219 Maryland Avenue | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| William | | | Almond | Ella | Jones | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address |
| None | | | 213-14-0874 | | Records, Springfield State Hospital | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> | | | | | | | | weeks | |
| 485X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>491X</u> | | | | | | | | | |
| (b) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| CBS, associated with alcohol intoxication with psychotic reaction. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/8/66</u> , 19__, to <u>4/16/68</u> , 19__, that (I) (we) lost saw the deceased alive on <u>4/16/68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Octavio A. Ruiz, M.D.</u> | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>4/16/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz, M.D.</u> | | | | | 22e. ADDRESS <u>Springfield State Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | 23e. (County) (State) | |
| Burial | | 4-19-1968 | | Mt. Carmel Cem. | | Sykesville, Maryland 21784 | | Balto., Md. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Vm. Cook-Brooks, Inc. 1217 St. Paul St. Balto. | | | | | | DATE <u>APR 22 1968</u> | | <u>Charles J. Jones</u> | |



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|--|--|--|--|--|-------------------------------------|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| George | | | Winfield | | Ashe | | | | April 5, 1968 | | |
| 2b. HOUR | | | | | | | | | 8:30 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | 1/14/02 | | 66 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Carroll County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Sykesville | | | Springfield State Hospital | | | Custodian | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | | Balto. City | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1818 Clifton Avenue | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| Isaac Mitchell Ash | | | | | | | | | Emma Jane Ash | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| None | | | 212-07-2714 | | Records, Springfield State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CA of cecum with multiple metastasis. | | | | | | | | | | month | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| CBS, associated with alcohol intoxication with psychotic reaction. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | HOUR A.M. Month Day Year P.M. | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/22/66, 19__, to 4/5/68, 19__, that (I) (we) last saw the deceased alive on 4/5/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | | |
| Agustin del Campo | | | | | | | | 4/5/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | | |
| AGUSTIN DEL CAMPO MD | | | | | | | | Springfield State Hospital | | | |
| | | | | | | | | Sykesville, Maryland 21784 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | April 8, 1968 | | Mt. Carmel Cemetery | | | Upperco Balto. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Tipton - Eline Funeral Home Hampstead, Md. | | | | APR 8 - 1968 | | | Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

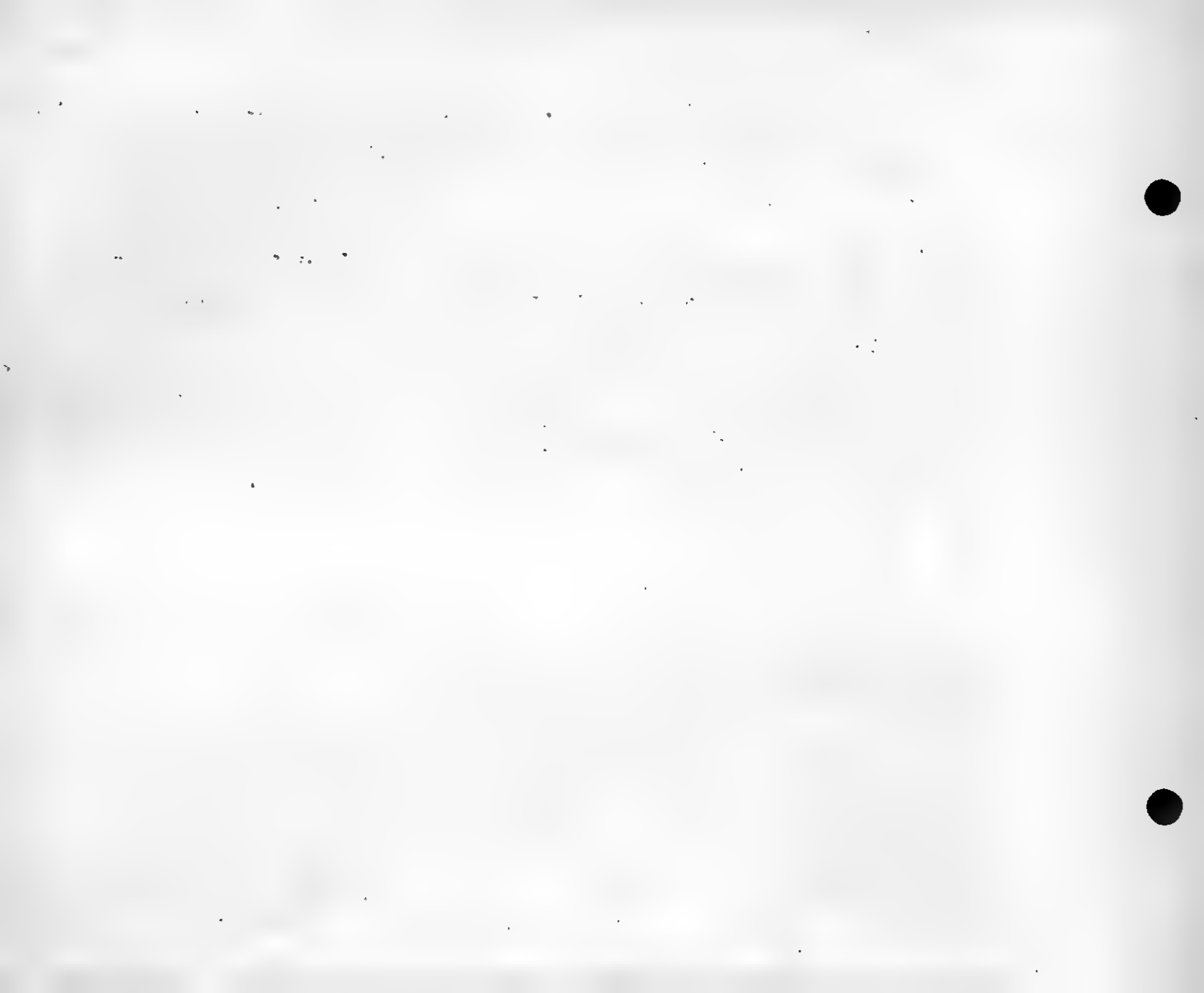
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13-68
30M REV 17-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05461

| | | | | | |
|---|----------------------|--|--|---|---|
| 1. DECEASED-NAME (Type or print) Elsie Mary Becraft | | | 2a. DATE OF DEATH Month 4 Day 14 Year 68 | | 2b. HOUR 1:42 M PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH JAN. 5, 1987 | | 6. AGE (In years last birthday) 81 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH Carroll | | 10. CITY OR TOWN OF DEATH Westminster | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Cr. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN Reisterstown | |
| 14. FATHER'S NAME First John Middle - Last HARRY | | 15. MOTHER'S MAIDEN NAME First UNKNOWN Middle - Last - | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO ? | | 17. INFORMANT Address Mrs. Bertie Kroll Reisterstown Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL BLEEDING - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. SITE UNKNOWN (b) - DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC HEART DISEASE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/2, 1968 , to 4/14, 1968 , that (I) (we) last saw the deceased alive on 4/14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Vincent J. Fiocco MD | | 22c. DATE SIGNED 4/14/68 | | 22d. PHYSICIAN'S NAME (Type) Vincent J. Fiocco | |
| 22e. ADDRESS Westminster, Md. | | 22f. ADDRESS Westminster, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4-17-68 | | 23c. NAME OF CEMETERY OR CREMATORY Old Oakland Cemetery | |
| 23d. LOCATION (City or Town) Sykesville | | (County) Md. | | (State) Md. | |
| 24. FUNERAL DIRECTOR Harry W. Knight | | 25a. RECEIVED BY REGISTRAR APR 17 1968 | | 25b. REGISTRAR'S SIGNATURE John Charles Justice | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1, 2, 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPT. OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|---|--|--|
| 1 DECEASED-NAME (Type or print) First Ernest D. Middle Brillhart Last | | | | | 2a DATE OF DEATH Month April Day 24 Year 1968 | | | 2b HOUR 12 ³⁵ P. M. | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH April 15, 1903 | | 6 AGE (In years last birthday) 65 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | | |
| 7a BIRTHPLACE (State or foreign country) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Carroll Md. | | | | | |
| 10 CITY OR TOWN OF DEATH Westminster | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Hospt. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Claims Investigator | | 12b KIND OF BUSINESS OR INDUSTRY Rail Road | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b COUNTY Carroll | | 13c CITY OR TOWN Manchester | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER Old Ft. School House Rd. | | | |
| 14 FATHER'S NAME First Franklin C. Middle Brillhart Last | | | | 15 MOTHER'S MAIDEN NAME First Maggie L. Middle Gettier Last | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | 16b SOCIAL SECURITY NO. A705-05-7450 | | 17 INFORMANT Address Gertrude Brillhart Manchester, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/22, 1968, to 4/24, 1968, that (I) (we) lost saw the deceased alive on 4/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John S. Harehey, M.D. | | | | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/24/68 | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN S. HAREHEY, M.D. | | | | | 22e. ADDRESS 8400 Mt. Westminster Rd. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE April 26, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery | | 23d. LOCATION (City or Town) (County) (State) Manchester Carroll Md. | | | | | |
| 24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md. | | | | | ADDRESS | | 25a. RECD BY REGISTRAR DATE APR 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 9 & 10 Film G400 5/2/68 **CERTIFICATE OF DEATH**

| | | | | | |
|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <i>Jesse Butler</i> | | | 2a. DATE OF DEATH Month <i>4</i> Day <i>21</i> Year <i>1968</i> | | 2b. HOUR M <i>1</i> |
| 3. SEX <i>M</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>Feb 15 - 1885</i> | | 6. AGE (in years last birthday) <i>83</i> YRS. | IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> |
| 7a. BIRTHPLACE (State or foreign country) <i>Mo.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Baltimore Carroll</i> Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Winfield</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Winfield</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>None</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Mo.</i> | | 13b. COUNTY <i>Mo.</i> | 13c. CITY OR TOWN <i>Winfield</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <i>1000</i> |
| 14. FATHER'S NAME First <i>W. J.</i> Middle <i>W.</i> Last <i>Butler</i> | | 15. MOTHER'S MAIDEN NAME First <i>W.</i> Middle <i>W.</i> Last <i>Butler</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>260x</i> | 17. INFORMANT <i>Charles Judge</i> Address <i>1000</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF <i>Heart Condition</i> (b) <i>Diabetes Mellitus</i> DUE TO, OR AS A CONSEQUENCE OF <i>9</i> (c) <i>9</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>260x</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>4</i> Day <i>21</i> Year <i>1968</i> P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/15</i> , 19 <i>66</i> , to <i>April 21</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>April 19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>H. H. Mastin M.D.</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>April 21 1968</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>H. H. MASTIN</i> | | 22e. ADDRESS <i>1000</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <i>4-21-68</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>1000</i> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <i>1100</i> | | ADDRESS <i>1100</i> | | 25a. REC'D BY REGISTRAR DATE <i>APR 24 1968</i> | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 175 (4)
30M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First EDNA | | | Middle GERTRUDE | | | Last CHESTER | | | 2a. DATE OF DEATH Month Day Year APRIL 24, 1968 | | | 2b. HOUR A 7:30 | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH 10-4-17 | | | 6. AGE (In years last birthday) 50 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Carroll | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | | 13b. COUNTY Baltimore City | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 3012 Greenspring Ave. | | | | | |
| 14. FATHER'S NAME First Middle Last Walter Crow | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rachel Cowley | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b. SOCIAL SECURITY NO. Unk. | | | 17. INFORMANT Records, Springfield State Hospital | | | Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforation of coronary artery aneurysm and hemorrhage into pericardial sac DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery thrombosis with arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4107 4201 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes & Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with alcohol intoxication, with psychotic reaction | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-23-60 , 19____, to 4-24-68 , 19____, that (I) (we) lost saw the deceased alive on 4-24-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Dr. Antonius Glahn</i> | | | 22c. DATE SIGNED 4-24-68 | | | 22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D. | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | | 23b. DATE 4-27--68 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | 25a. REC'D BY REGISTRAR DATE APR 29 1968 | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (11)
30M REV 4/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (Type or print) Grace Mary McDonough Conway | | | 2a. DATE OF DEATH Month 4 Day 13 Year 1968 | | 2b. HOUR 4:45A M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 7/6/03 | | 6. AGE (In years lost birthday) 64 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Penna. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Carroll County Md. | | |
| 10. CITY OR TOWN OF DEATH Sykesville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Balto. City | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 1128 Hewitt Way | |
| 14. FATHER'S NAME First Middle Last Peter McDonough | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Kearney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. None | 17. INFORMANT Mr Edward N Conway Address Same Records, Springfield State Hospital | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 486X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause last. 410X (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Biliary Calculi 2° to Chronic Alchoholism | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11/67 , 19____, to 4/13/68 , 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gloclite G. Sagisi | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 4/13/68 | |
| 22d. PHYSICIAN'S NAME (Type) Gloclite G. Sagisi | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4/16/68 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc | | | ADDRESS Baltimore, Maryland | | 25a. REC'D BY REGISTRAR DATE APR 15 1968 |
| | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

FOR STATE
HEALTH DEPT. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|------------------------------|--|--|---|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | Month Day Year | |
| MARY ELIZABETH COCKSON | | | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> | | 4-23 1968 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | 7 UNDER 1 YEAR | 8 UNDER 24 HRS | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| F | W | FEB 19-1902 | 66 YRS | MONTHS | DAYS | Month Day Year | | 4-23 1968 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | CARROLL | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| UNIONTOWN | | | MAIN ST. | | | BOARDING HOUSE | | NURSE | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY, YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MD | | | CARROLL | | | UNIONTOWN | | YES | |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 13e STREET AND NUMBER | | | |
| GUY M. COOKSON | | | ADA ROYER | | | MAIN ST. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | ADDRESS | |
| NO | | | 220-30-0804 | | | GRACE COOKSON | | UNIONTOWN MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT (acute) | | | | | | | | | Sudden |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 7-10 | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21b P. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspect an <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| W GLENN SPEICHER | | | ASSISTANT MEDICAL EXAMINER | | | 4-23-68 | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS | | | |
| W GLENN SPEICHER | | | 13100 W. 91st Road | | | Carroll | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| CREMATION | | 4-26-68 | | FT LINCOLN | | BLADENSBURG, MD | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| D N Hutzler & Sons | | | | New Windsor, Md | | DATE APR 26 1968 | | J. Charles George | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled to by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME (Type or print) Fannie M. Culisn | | | 2a. DATE OF DEATH Month April Day 9 Year 1968 | | | 2b. HOUR 5:45 M | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH 10/23/1887 | | 6 AGE (in years last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) Cornwall Co | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Cornwall Md | | | | |
| 10 CITY OR TOWN OF DEATH Manchester | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Longview Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b COUNTY Baltimore | | 13c CITY OR TOWN Glyndon | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER Box 86 | |
| 14. FATHER'S NAME First Middle Last Albert W. Fuss | | | 15. MOTHER'S MAIDEN NAME First Middle Last Margaret E. Woods | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 219-20-5776 | | 17. INFORMANT Maude E Geist | | | Address 24 Butler Rd Glyndon Md | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis | | | | | | | | | 12 days | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) arteriosclerotic Heart Disease | | | | | | | | | 1 yr | |
| (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 yrs | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22 , 1968, to 4/7 , 1968, that (I) (we) last saw the deceased alive on 4/6 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE W. H. Foard M.D. | | | DEGREE M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/9/68 | | |
| 22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D. | | | 22e. ADDRESS Manchester, Md 2103 | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | | | 23b. DATE April 11, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Pikesville, Md. | | |
| 24. FUNERAL DIRECTOR J. F. Eline & Sons | | | ADDRESS Reisterstown, Md | | | 25a. REC'D BY REGISTRAR DATE APR 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05466

05468

| | | | | | |
|--|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY DORSEY RUN-RA. HOWARD | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESTVILLE | | c. LENGTH OF STAY IN 1b 4-10-68 to 4-21-68 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JESSUP | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL | | | d. STREET ADDRESS DORSEY RUN ROAD Box 224 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last PHILIP LOREN CURLEY | | | 4. DATE OF DEATH Month Day Year 4 21 1968 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 3-2-03 | | 9. AGE (In years last birthday) 65 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (County & State or foreign country) MD. | |
| 13. FATHER'S NAME HUGH CURLEY dec. | | 14. MOTHER'S MAIDEN NAME MYRTLE CASTLE dec. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO 579-12-7808 | | 17. INFORMANT Hospital records. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Acute Myocardial infarction DUE TO (b) Coroniosclerotic Heart Disease DUE TO (c) Chronic Alcoholism | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Gracito V. Patricio | | | 22b. DATE SIGNED 4/21/68 | | |
| 22c. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO | | | 22d. ADDRESS Springfield State Hosp | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 4-24-68 | 23c. NAME OF CEMETERY OR CREMATORY Springfield Cem | | 23d. LOCATION (City or town) (County) (State) Lanham Md | |
| 24. FUNERAL DIRECTOR W. H. W. W. W. W. W. | | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

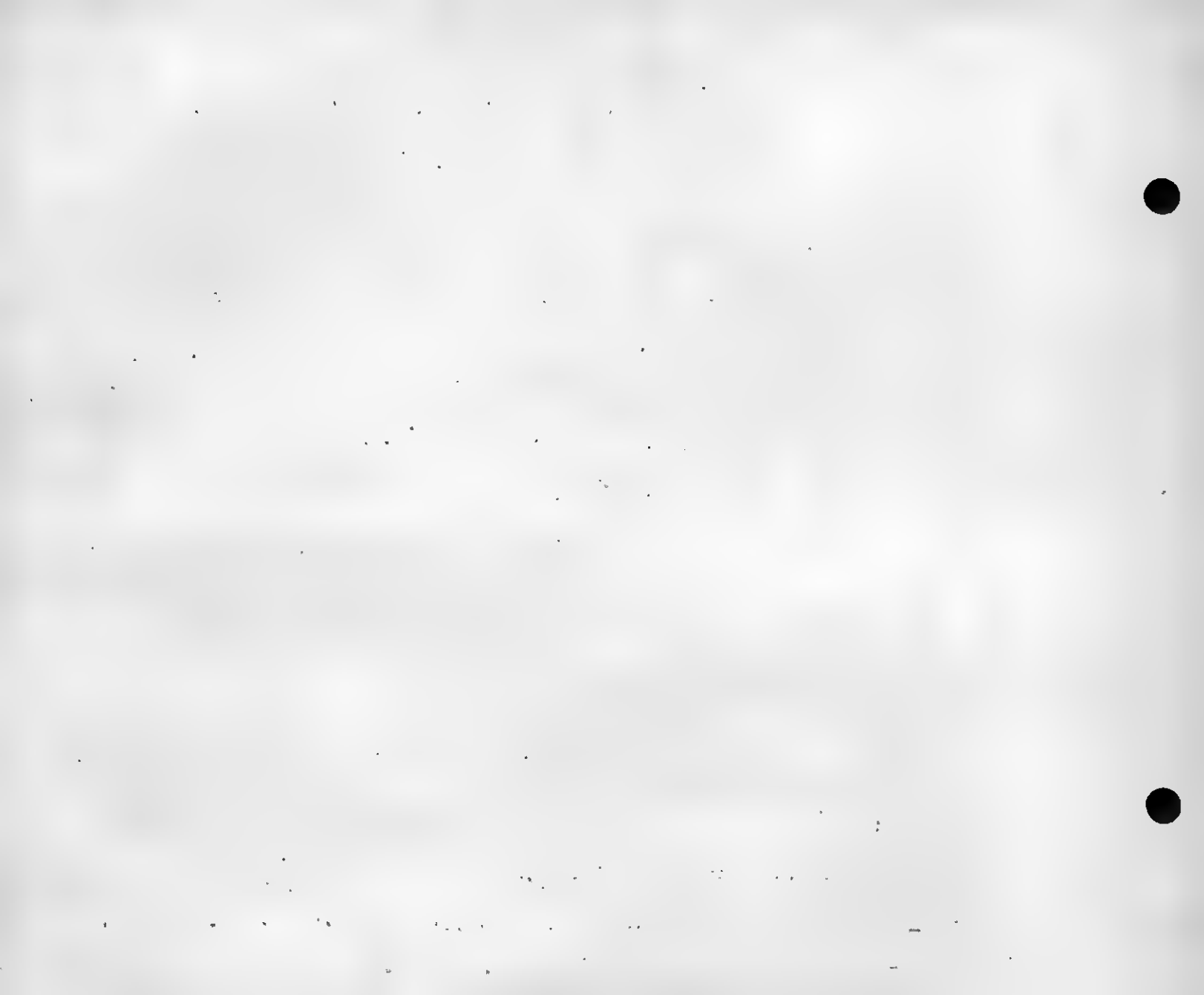
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. DECEASED NAME (Type or print) MARY FRANCES CURTIS | | | 2a. DATE OF DEATH Month April Day 9 Year 1968 | | | 2b. HOUR 5P M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 12/29/1908 | | 6. AGE (in years lost birthday) 59 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Cannell Md. | |
| 10. CITY OR TOWN OF DEATH Manchester | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Long View Nursing Home 12801 Main | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Brick Store Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | 13b. COUNTY Cannell | | 13c. CITY OR TOWN Westminster | | 13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 321 E Main St | | 14. FATHER'S NAME First Len Middle Curtis Last Curtis | | 15. MOTHER'S MAIDEN NAME First Anna R. Middle Brunell Last Brunell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 218-36-0421 | | 17. INFORMANT Mrs Catherine Thompson, Uprens. Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) gastro-intestinal hemorrhage 18:30 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma ovary Rt Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 1 yr 1 yr | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/30, 1968 , to 4/9, 1968 , that (I) (we) lost saw the deceased alive on 4/9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W.H. Foad M.D. | | 22c. DATE SIGNED 4/9/68 | | 22d. PHYSICIAN'S NAME (Type) W.H. Foad M.D. | | 22e. ADDRESS 25 N Main St Manchester, Md 21102 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 12, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Black Rock Cemetery | | 23d. LOCATION (City or Town) (County) (State) Butler Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md. | | | | 25a. REC'D BY REGISTRAR DATE APR 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED-NAME (Type or print) LAURA S. DUNN | | | 2a. DATE OF DEATH April Month 27 Day 1968 Year | | 2b. HOUR 2:52 M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MAY 21, 1887 | | 6. AGE (in years lost birthday) 80 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) BALTIMORE MD - U.S.A. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH CARROLL CO. Md. | | |
| 10. CITY OR TOWN OF DEATH WESTMINSTER | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE-WIFE AND SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | 13b. COUNTY CARROLL | 13c. CITY OR TOWN WESTMINSTER | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 191 DAVID RD | |
| 14. FATHER'S NAME First Middle Last HENRY J. STEINKAMP | | 15. MOTHER'S MAIDEN NAME First Middle Last ELEANOR KEYSOR | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) — (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 215-05-6211A | | 17. INFORMANT Address WESTMINSTER, MD MRS DAVID T. YOUNG, NEW WINDSOR ROAD, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4/25/68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) — | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 27, 1968 , to April 27, 1968 , that (I) (we) last saw the deceased alive on April 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE John S. Harsway, M.D. | | DEGREE M.D. | | 22c. DATE SIGNED 4/27/68 | |
| 22d. PHYSICIAN'S NAME (Type) JOHN S. HARSWAY MD. | | 22e. ADDRESS Yonkers St. Westminster, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM. | |
| 23d. LOCATION (City or Town) (County) (State) BALTIMORE CITY MD. | | 24. FUNERAL DIRECTOR ADDRESS 27 Maple St. Westminster, Md. | | | |
| 25a. REC'D BY REGISTRAR DATE APR 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

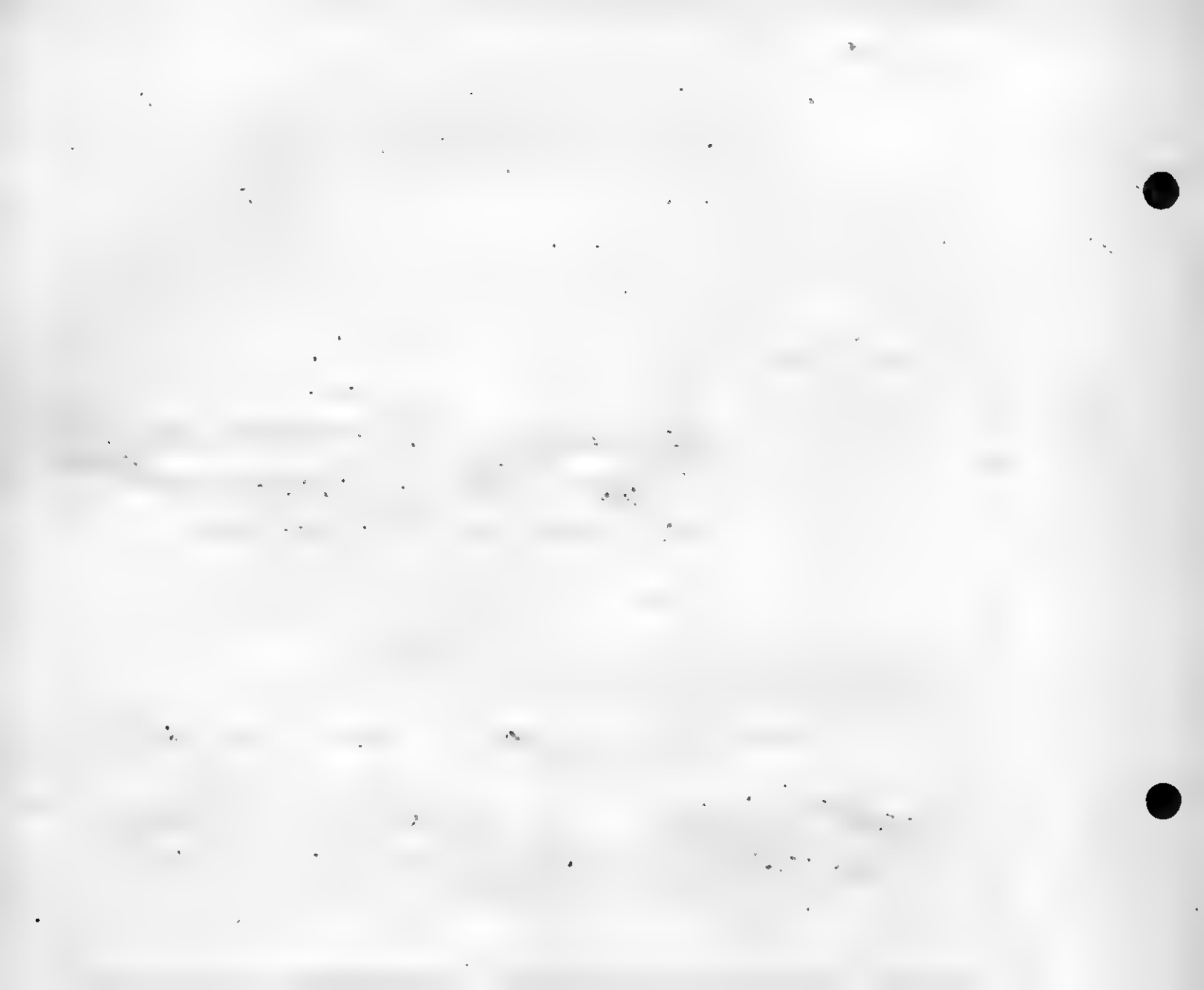
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | |
|---|--|--|--------|---|-----------------------|--|----------|--|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| J. BLAINE EDMONDSON | | | | | 4 Month 9 Day 68 Year | | A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Male | | White | | April 24, 1886 | | 81 YRS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | Carroll, Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Finksburg | | Route 1 | | Well Driller | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | Carroll | | Finksburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Route 1 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| Alford | | Edmondson | | Josephine Brothers | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | |
| No | | 218-14-4799 | | Mrs. Margaret A. Edmondson Same As #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Coronary Thrombosis in aorta | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Myocardial Infarction, Decompensating | | | | | | | | |
| (c) | | | | | | | | |
| General arteriosclerosis | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-1-1968, to 4-9-1968, that (I) (we) last saw the deceased alive on 4-2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. PHYSICIAN'S NAME (Type) | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22d. DATE SIGNED |
| | | James Saffell MD | | | | | | 4-9-68 |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | |
| | | Beisterstown, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 4/12/1968 | | Providence | | Gamber, Carroll, Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| C. M. Waltz, Box 241, Sykesville, Md. | | DATE | | APR 15 1968 | | Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First CHARLES | | Middle WEST | | Last ELLSWORTH, SR. | | 2a. DATE OF DEATH Month Day Year April 30, 1968 | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH 8-31-1892 | | | 6. AGE (In years lost birthday) 75 YRS. | | 2b. HOUR 8:30 A M. | |
| 7a. BIRTHPLACE (State or foreign country) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Government worker (ret.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 8207 Mooreland Lane | |
| 14 FATHER'S NAME First Middle Last Albert Ellsworth | | | 15. MOTHER'S MAIDEN NAME First Middle Last Frances Rolfe | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) Yes 1918-1919 | | | 16b. SOCIAL SECURITY NO. 266-76-6470 | | 17 INFORMANT Address Records, Springfield State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia with multiple abscesses DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days or weeks | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 491 X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-1-68 , 19____, to 4-30-68 , 19____, that (I) (we) lost saw the deceased alive on 4-30-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Octavio A. Ruiz</i> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 4-30-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D. | | | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem. | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | 25a. REC'D BY REGISTRAR DATE MAY 2 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



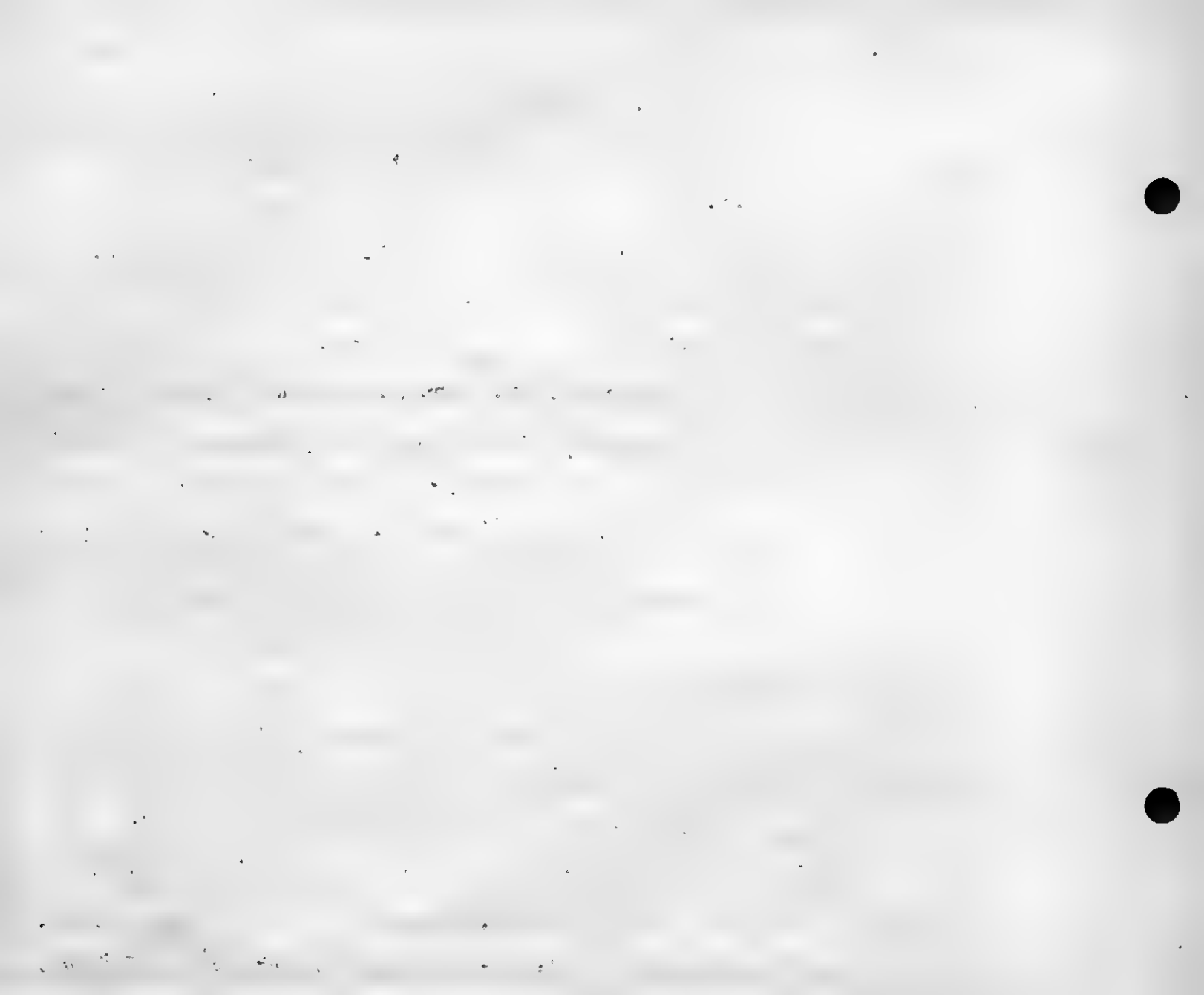
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05473

| | | | | | | | | | | | |
|---|--|---|--------|---|--|---|---------------|---|----------------------|--------------------------------|--|
| 1. DECEASED NAME (Type or print) JOHN | | First | Middle | Last | 2a. DATE OF DEATH 4 Month 29 Day 68 Year | | 2b. HOUR M | | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH Oct. 19, 1904 | | 6. AGE (In years last birthday) 63 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 7. UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll, | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. 3 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired- Game Farm Mgr. | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Sykesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER R.D. 3 | | | |
| 14. FATHER'S NAME John | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME Meda | | First | Middle | Last Gaver | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 214-20-1585 | | 17. INFORMANT Mr. John L. Esworthy | | Address Same As #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Recurrent Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary occlusion, Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | |
| | | | | | | | | 4 yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7.2.01 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1964 to APR 29, 1968 , that (I) (we) last saw the deceased alive on Jan 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sani Okutman | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4.29.68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Sani Okutman | | 22e. ADDRESS Sykesville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/3/1968 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Gardens | | 23d. LOCATION (City or Town) | | (County) | | (State) Carroll, Md. | |
| 24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAY 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

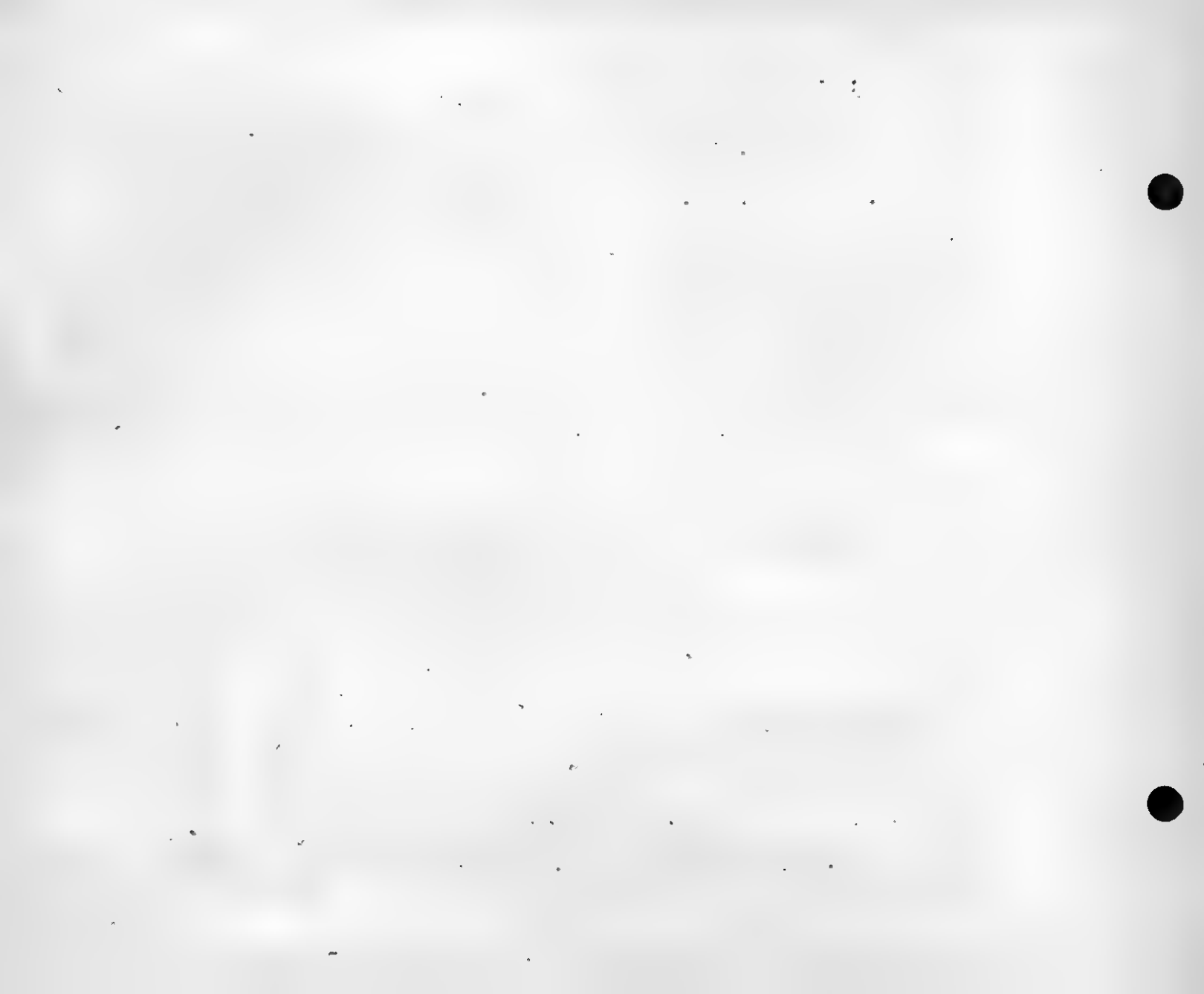
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | |
|---|---------|--|--------|--|---|---|-----------------------------------|---|-----------|--|
| 1. DECEASED NAME (Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| DAVID W. FAIDLEY, SR. | | | | | 4-10 | | 4 | 10 | 1968 | 4:35 A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years not birthday) | 7c. DATE PRONOUNCED DEAD | | Month | Day | Year | 2d. HOUR |
| Male | White | Nov. 11, 1939 | | 28 YRS | 4 | | 10 | 1968 | 8:35 A.M. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Penna. | | U.S.A. | | | | Carroll, Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Woodbine | | R.D. 1 | | | Carpenter | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 3d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | Carroll | | Woodbine | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Carl | | | | Faidley | Audra | | | | Myers | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | |
| No | | 212-38-5506 | | Mrs. Gloria Jean Faidley | | Same As #3 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushed chest (multiple injuries) | | | | | | | | | | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 9121 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | 4-10 1968 | | Tractor upset on him | | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | Instantly on Farm | | R.D. 1 Woodbine Carroll Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | |
| W. Glenn Speicher M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | |
| | | ADDRESS (Street, town or county) | | | | | | | | |
| | | 1350 Morgan Rd. Carroll Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 4/13/1968 | | Morgan Chapel | | Carroll, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| C. M. Waltz, Box 241, Sykesville, Md. | | | | | | DATE APR 15 1968 | | Charles Judge | | |



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|-----------------------------|---|---|------------------------|---|--|----------------------------------|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | 2b HOUR | |
| JOHN ANDERSON FOSSON | | | | | | Month Day Year | | APRIL 26 1968 2:55 A | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER YEAR MONTHS | 8 IF UNDER 24 HRS YEAR | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| Male | White | 10-12-11 | 56 YRS | | | Month Day Year | | APRIL 26, 1968 19 2:55 A M | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CIT ZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | Md | |
| West Virginia | | U.S.A. | | | | Carroll | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Sykesville | | | Springfield State Hospital | | | Roofers | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE | | | 13b CITY OR TOWN | | | 13c INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | |
| Maryland | | | Baltimore City Baltimore | | | NO <input checked="" type="checkbox"/> | | 3021 Guilford Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Lewis | | | Fosson | | | Lillian Worthington | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT ADDRESS | | | |
| Yes | | | 1942-1946 | | | 235-05-7773 Records, Springfield State Hospital | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subdural hematoma, right</u> | | | | | | | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (b) <u>4X</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | 20 AUTOPSY? |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | 9:00 P.M. 4-25-1968 | | | Apparently fell out of bed in what appeared to be seizure | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| Men's Group | | | I Ward, | | | Springfield State Hospital, Sykesville Carroll | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| 22b. DATE SIGNED | | | 22c. DATE SIGNED | | | | | | |
| 4-26-68 | | | 4-26-68 | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | |
| W. Glenn Speicher, M. D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | 4-30-1968 | | | Baltimore National Cem. | | | |
| 24 FUNERAL DIRECTOR | | | 23d LOCATION (City or Town) (County) (State) | | | 25a REC'D BY REGISTRAR | | | |
| George J. Gonce-4001 Ritchie Hwy., Baltimore | | | Baltimore, Maryland | | | DATE MAY 2 1968 | | | |
| | | | 25b REGISTRAR'S SIGNATURE | | | | | | |
| | | | Charles Judge | | | | | | |



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) JAMES Earl F. L. R | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year April 30 1968 | | | 2b. HOUR 6.10 PM | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 8-23-24 | | | 6. AGE (In years last birthday) 73 | | |
| 7a. BIRTHPLACE (State or foreign country) Kansas | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Carroll | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Missionary | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Baltimore | | | 13b. COUNTY Carroll | | | 13c. CITY OR TOWN Booth | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER 3939 Roland Avenue | | | 14. FATHER'S NAME First Middle Last Oscar Fowler | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Doone Connor | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes | | | 16b. SOCIAL SECURITY NO. W.W.I | | | 17. INFORMANT Records, Springfield State Hospital | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 4369 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) 337X Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hours | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic brain syndrome assoc. w/senile brain disease with psychotic reac. Diabetes mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-24-67 , 19__, to April 30 , 19 68 , that (I) (we) last saw the deceased alive on April 30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Anastasio M. Castiello, M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED April 30, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) Anastasio M. Castiello | | | | | | 22e. ADDRESS Springfield State Hospital, Sykesville | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | 23b. DATE May 2, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | | 23d. LOCATION (City or Town) (County) (State) Washington 18, D.C. | | |
| 24. FUNERAL DIRECTOR H. J. Schmitt | | | | | | ADDRESS Owings Mills, Md. | | | 25a. RECORD BY REGISTRAR MAY 3 1968 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

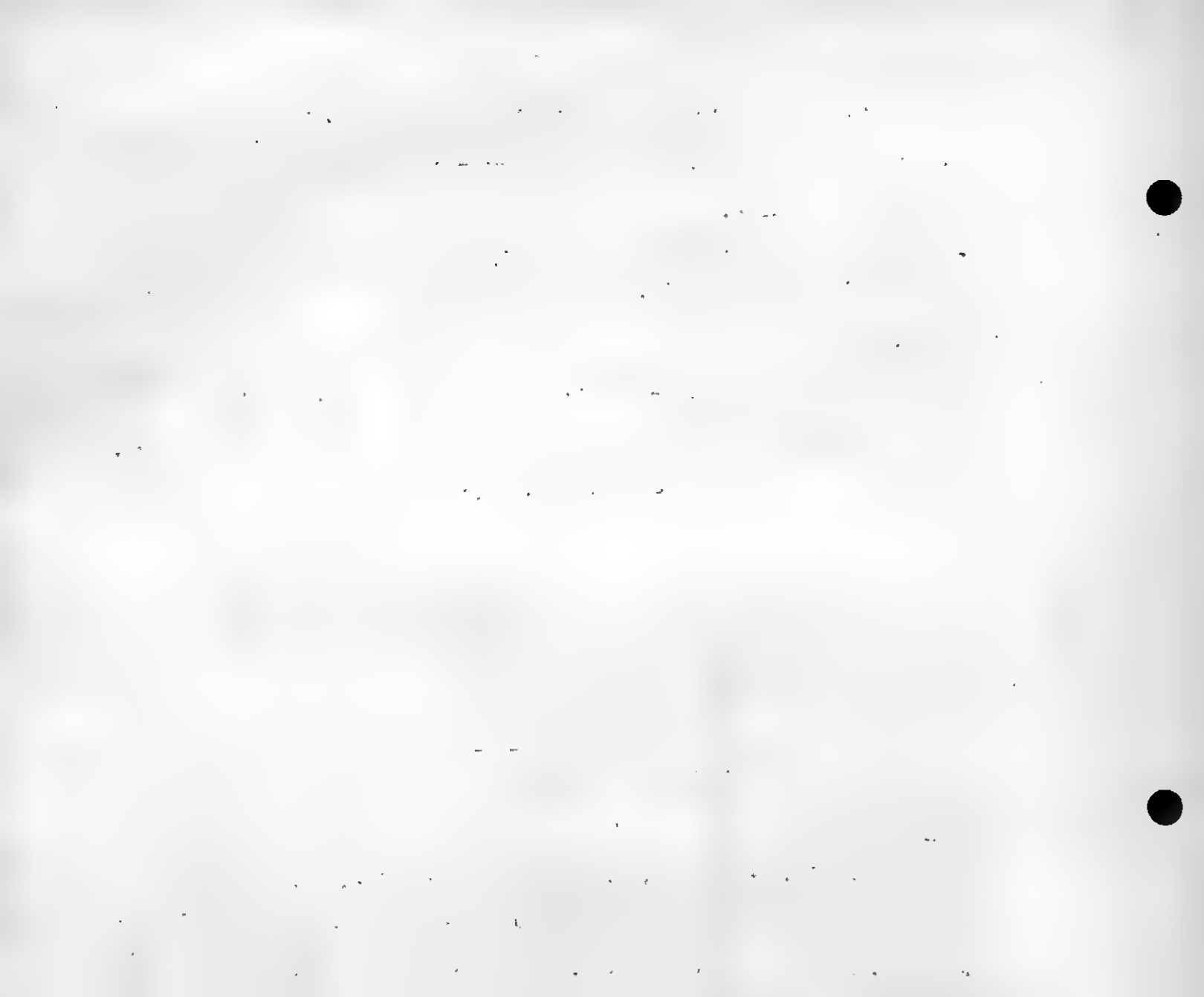


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corollary papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Florine NMN Garner | | | 2a. DATE OF DEATH Month April Day 20 Year 1968 | | | 2b. HOUR 9:25 PM | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 4-26-05 | | 6. AGE (In years last birthday) 62 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Balto. City Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3308 Auchentoroly Terrace | |
| 14. FATHER'S NAME First Eugene Middle Holley Last | | | 15. MOTHER'S MAIDEN NAME First Agnes Middle Smothers Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO 220-22-9680 | | 17. INFORMANT Springfield Hosp. Records | | Address Sykesville Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) pulmonary Embolus 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary site undetermined DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465 X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-28-67 , 19 67 , to 4-25-68 , 19 68 , that (I) (we) last saw the deceased alive on 4-20-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Gracito V. Patricio | | | | DEGREE M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 4/20/68 | |
| 22d. PHYSICIAN'S NAME (Type) Gracito V. Patricio, M.D. | | | | 22e. ADDRESS Sykesville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4-25-68 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Charles R. Law | | | | ADDRESS 802 Madison Ave., Balto., Md. | | 25a. REC'D BY REGISTRAR APR 23 1968 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |



CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME (Type or print) <i>DePaul</i> | | | 2a. DATE OF DEATH Month <i>4</i> Day <i>30</i> Year <i>68</i> | | | 2b. HOUR <i>6:10</i> M | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>Jan. 30, 1894</i> | | 6. AGE (In years last birthday) <i>74</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Carroll</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Westminster</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. Gen.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, ever, retired) <i>Retired from government</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Balto.</i> | | 13c. CITY OR TOWN <i>Reisterstown</i> | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13a. STREET AND NUMBER <i>Rt. 2</i> | |
| 14. FATHER'S NAME First <i>Jay</i> Middle Last <i>Gore</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Ella</i> Middle <i>M.</i> Last <i>Hipsley</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, give year or dates of service) <i>Yes</i> | | 16b. SOCIAL SECURITY NO <i>212-32-4926</i> | | 17. INFORMANT Address <i>Mrs. Dorothy B. Gore Reisterstown, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>RECENT EXTENSION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>HYPERTENSIVE + ARTERIOSCLEROTIC DIS.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>13 DAYS</i> <i>YEARS</i> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic HEART DISEASE</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/17, 1968</i> to <i>4/30, 1968</i> , that (I) (we) last saw the deceased alive on <i>4/30, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>John J. Moore</i> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>4/30/68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>May 3, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>All Saints</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>J. F. Elme & Sons</i> ADDRESS <i>Reisterstown, Md.</i> | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAY 2 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>John J. Moore</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

5479

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) WILLIAM THOMAS GREER | | | 2a. DATE OF DEATH Month 4 Day 3 Year 68 | | 2b. HOUR A.M. OR P.M. 3:20 AM |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH 06/18/10 | | 6. AGE (In years last birthday) 57 YRS. | IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH Carroll | | 12b. KIND OF BUSINESS OR INDUSTRY Farmer |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Monkton | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER ----- |
| 14. FATHER'S NAME First Blanche Middle G. Last Greer | | | 15. MOTHER'S MAIDEN NAME First Fannie Middle Fratic Last Fratic | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Hospital Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute purulent Peritonitis DUE TO, OR AS A CONSEQUENCE OF (b) Perforation of Urinary Bladder DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA of URINARY Bladder Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: due to asphyxia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days |
| | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CBS assoc. with Trauma, following other trauma, with psychotic react. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that Dr (this hospital) attended the deceased from 10/27 , 19 68 , to 4/3 , 19 68 , that he (we) last saw the deceased alive on 4/3 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above he (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE Suha Ozgun | | | | 22c. DATE SIGNED 4/3/68 | |
| 22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D. | | | | 22e. ADDRESS Springfield State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Apr. 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Cannaday Cemetery | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd, Towson, 21204 | | 23d. LOCATION (City or Town) (County) (State) Floyd, Virginia | | 25a. REC'D BY REGISTRAR APR 5 - 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

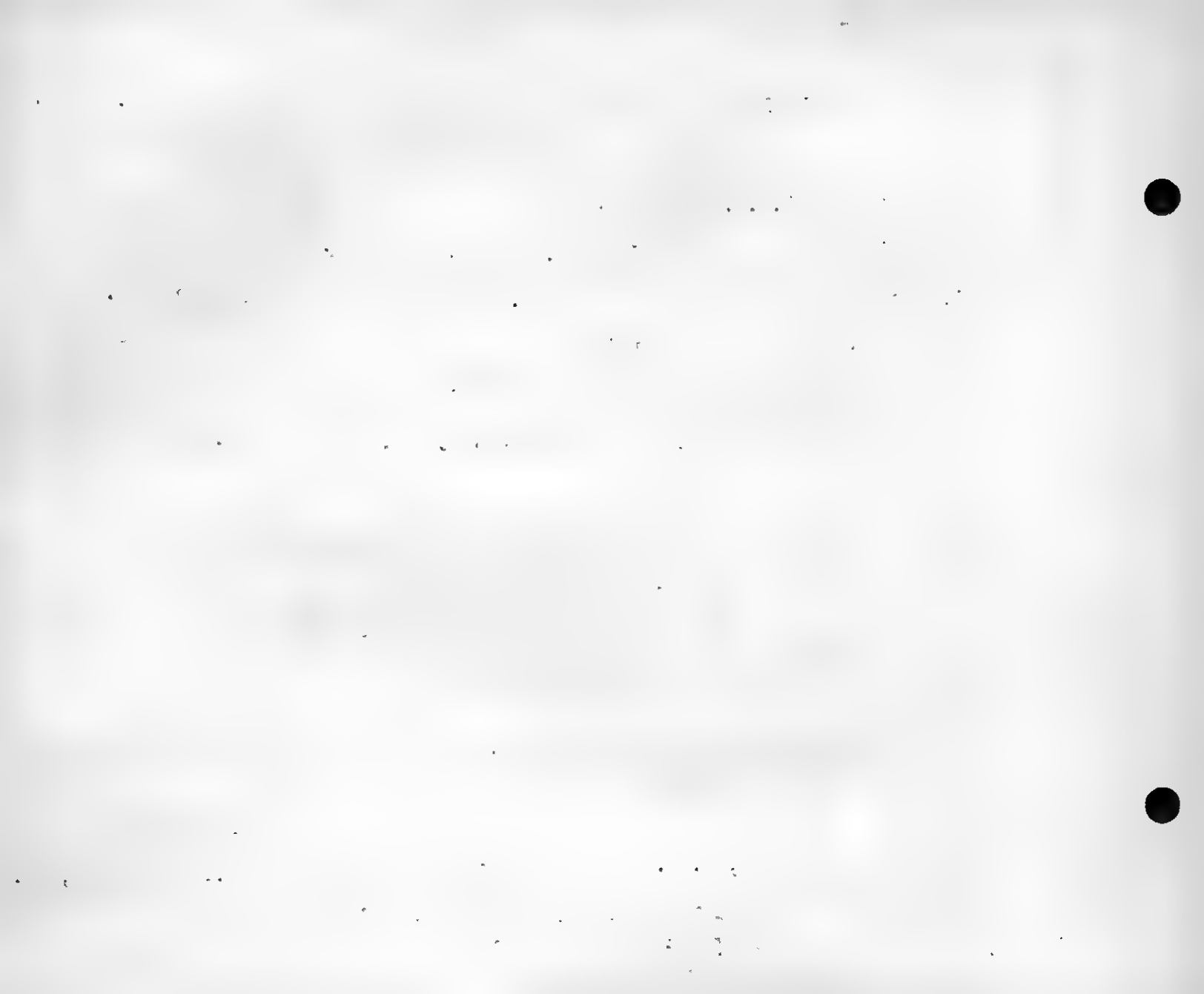
VR 15-14
30M REV. 7/68

00178

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00480

| | | | | | | | | | | | |
|--|--|---|---|--|----------------------|--|--|---|-----------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) | | | First BENJAMIN | Middle (NMN) | Last GUTIN | 2a. DATE OF DEATH Month 4 Day 3 Year 68 | | | 2b. HOUR P 12:45M | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH 05/08/13 | | 6. AGE (In years last birthday) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Russia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. (Naturalized) | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield St. Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 2201 Lynbrook Ave. | | | |
| 14. FATHER'S NAME First Leon Middle Gutin Last Gutin | | | 15. MOTHER'S MAIDEN NAME First Mollie Middle Milamudr Last Milamudr | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. none | | 17 INFORMANT Address Hospital Records | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary thrombosis, myocardial infarction minutes 400 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 400/Schizophrenic reaction, catatonic type | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 7/31 , 19 46 , to 4/3 , 19 68 , that he (we) last saw the deceased alive on 4/3 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Suha Ozgun | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 4/3/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D. | | | | 22e. ADDRESS Springfield State Hosp., Sykesville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4-4-68 | | 23c. NAME OF CEMETERY OR CREMATORY Young Men's Hebrew Cemetery | | 23d. LOCATION (City or Town) (County) (State) Windsor Mill Pa Md. | | | | | |
| 24. FUNERAL DIRECTOR JACK HENNIS INC. 2180 EUTAW PK. Baltimore Md | | | | 25a. REC'D BY REGISTRAR DATE APR 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Jones | | | | | |

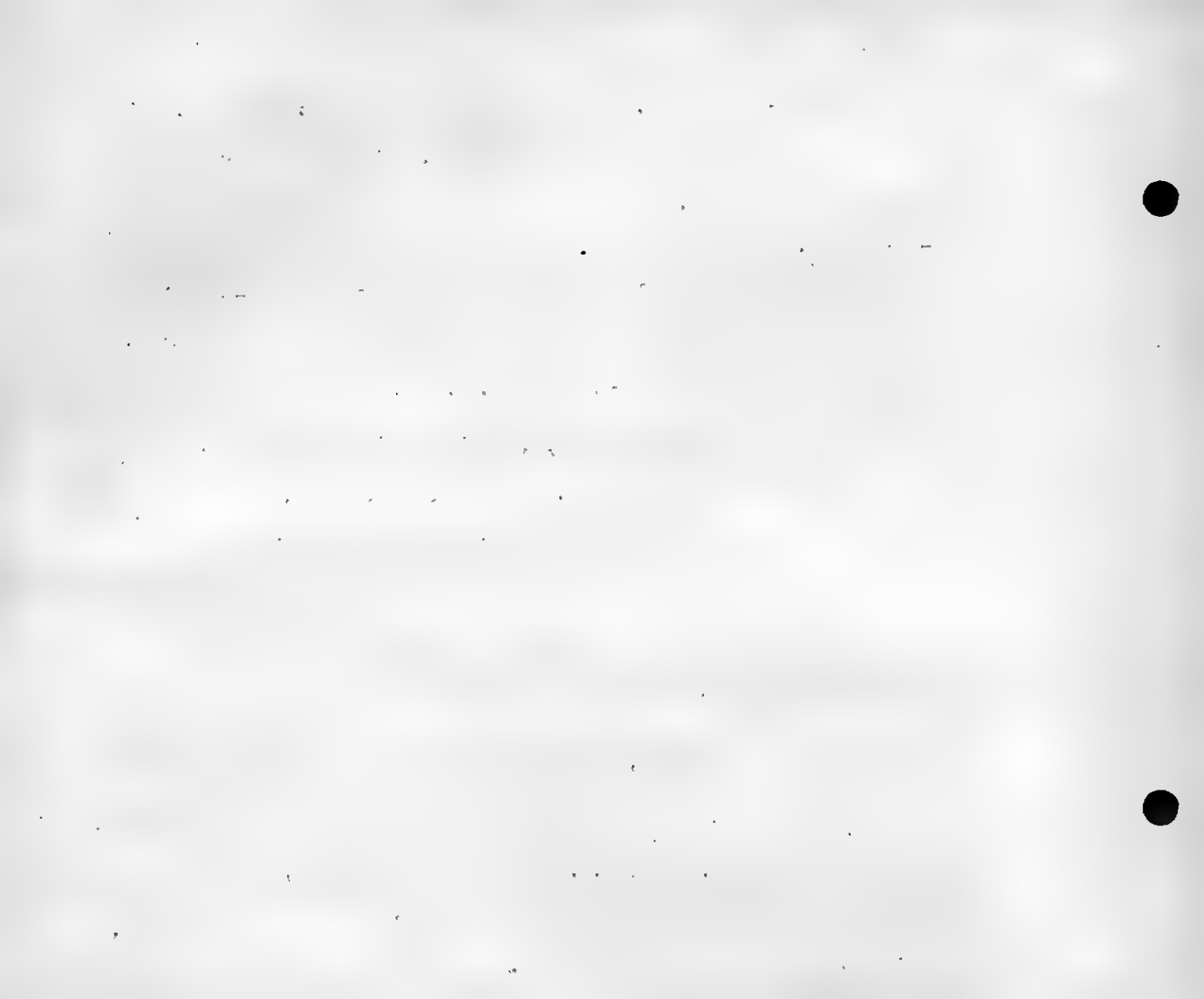


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PHYSICIAN AND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME (Type or print) Arthur L. Haines | | | 2a. DATE OF DEATH Month April Day 26 Year 1968 | | | 2b. HOUR 3 P.M. | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH June 4, 1905 | | 6. AGE (In years lost birthday) 62 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | | | Md. | |
| 10. CITY OR TOWN OF DEATH Rural--Woodbine | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 1 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired painter | | | 12b. KIND OF BUSINESS OR INDUSTRY house | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Rural--Woodbine | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Levi Middle Haines Last Haines | | | 15. MOTHER'S MAIDEN NAME First Amanda Middle Jenkins Last Jenkins | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 215-14-1997 | |
| 17. INFORMANT Mrs. Evelyn Haines | | | Address same as #13 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized, hypertension, 412.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioclerotic heart disease, C V A, DUE TO, OR AS A CONSEQUENCE OF (c) Coronary thrombosis and cardiac arrest | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1964 through 4/26/68 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19____, to April 26, 1968 , that (I) (we) last saw the deceased alive on April 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Howard E. Hall | | | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED April 26, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D. | | | | 22e. ADDRESS Sykesville, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4-29-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Winfield church of God, Carroll Co. Md. | | 23d. LOCATION (City or Town) (County) (State) Carroll Co. Md. | | 23e. REGISTRAR'S SIGNATURE Charles Judge | | |
| 24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md. | | | | 25a. REC'D BY REGISTRAR DATE APR 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



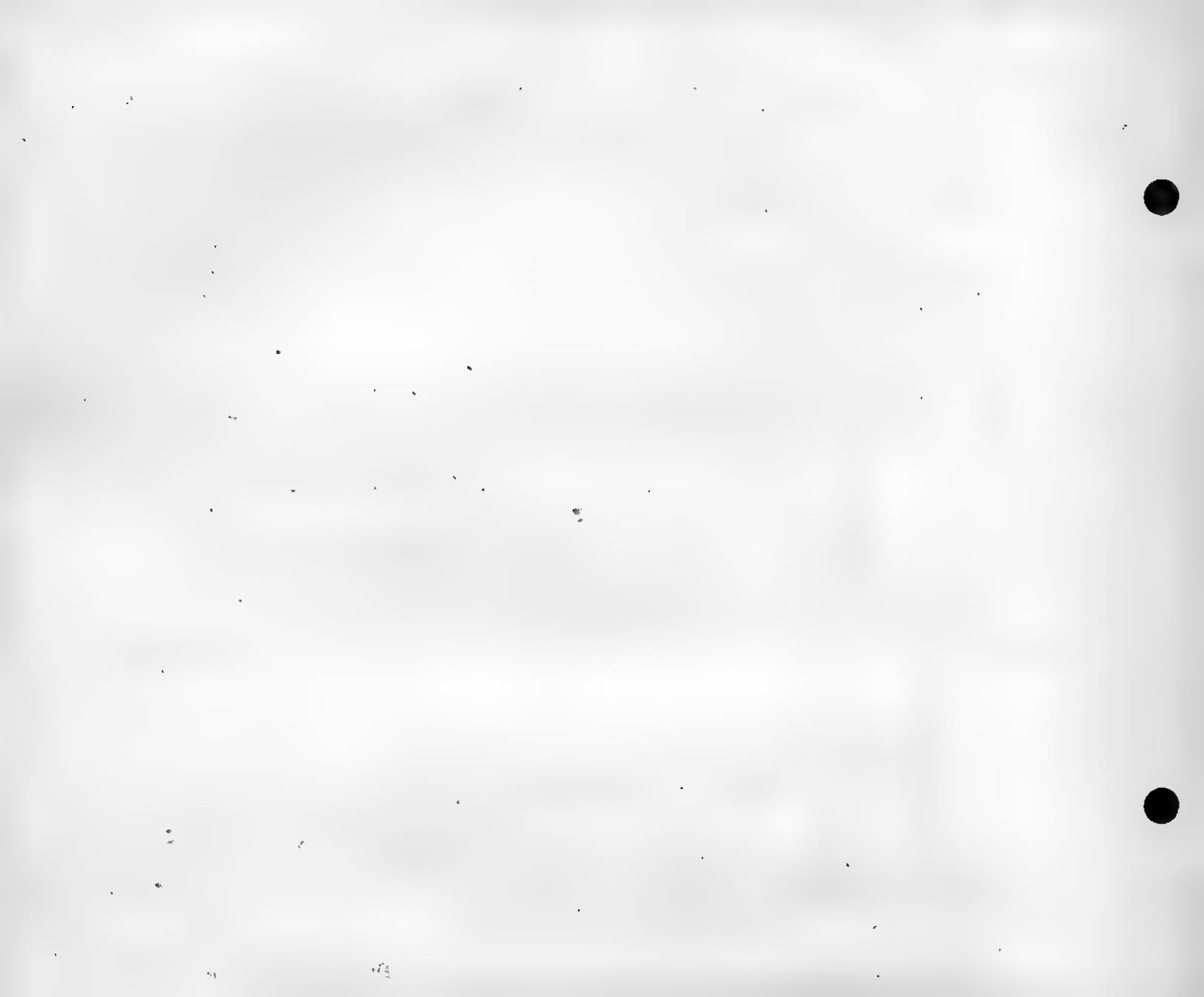
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|--|-----------------|--|--|--|---|---|--|--|
| 1 DECEASED NAME (Type or Print) MAMMIE SOPHIA HAINES | | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 16 Year 1968 | | | 2b HOUR 2:45 M | | |
| 3 SEX F | 4 RACE W | 5 DATE OF BIRTH 5/6/1895 | 6 AGE (in years last birthday) 72 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Month 4 Day 16 Year 1968 | | |
| 7a BIRTHPLACE (State or foreign country) U.S. MARYLAND | | 7b CITIZEN OF WHAT COUNTRY? U.S. MARYLAND | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH CARROLL | | |
| 10 CITY OR TOWN OF DEATH UNION BRIDGE | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 32 S. MAIN ST. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEKEEPER AT HOME | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a U.S.A. RESIDENCE (Where deceased lived if institution: Residence before 13c. CITY OR TOWN MARYLAND 13b COUNTY CARROLL UNION BRIDGE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 32 S. MAIN ST | | | | |
| 14. FATHER'S NAME First CHARLES E. WELLER Middle Last | | | 15. MOTHER'S MAIDEN NAME First ANNA B. RENNER Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year of dates of service) NO | | | 16b SOCIAL SECURITY NO 420-18-0550 | | | 17 INFORMANT ADDRESS MRS CATHERINE HYDE UNION BRIDGE MD | | |
| 18 CAUSE OF DEATH (Enter only one cause per Part I. Death was caused by IMMEDIATE CAUSE (a) Cerebral Thrombosis (acute) DUE TO, OR AS A CONSEQUENCE OF Arterio Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF decompensation (c) Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden several years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | |
| 19a DATE OF OPERATION 4-19-68 | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month Day, Year 19 HOUR A.M. P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE W. Glenn Speicher | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 4-16-68 | | |
| EXAMINER'S NAME (Type) W. GLENN SPEICHER | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS 1301 W. Preston St. Baltimore, Md. | | |
| 23a B. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b DATE 4-19-68 | | 23c NAME OF CEMETERY OR CREMATORY MT VIEW CEM. | | 23d LOCAT ON (City or Town) UNION BRIDGE, MD | | |
| 24 FUNERAL DIRECTOR D. H. Hertzler & Sons Union Bridge, Md. | | | 25a REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

11281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last Hattie Elizabeth Hall | | | 2a. DATE OF DEATH Month Day Year April 19, 1968 | | 2b. HOUR PM 10:32 |
| 3 SEX Female | | 4 RACE White | 5. DATE OF BIRTH Sept. 15, 1888 | | 6 AGE (In years last birthday) 79 YRS |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 650 E. 35th Street |
| 14. FATHER'S NAME First Middle Last ? Earhart | | | 15. MOTHER'S MAIDEN NAME First Middle Last unk. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unk. | | 16b. SOCIAL SECURITY NO. 213-05-9851-1 | | 17. INFORMANT Address Springfield Hospital records, Sykesville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4330 (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS associated with cerebral arteriosclerosis without qualifying phrase | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 7, 1966 , to Apr. 19, 1968 , that (I) (we) lost saw the deceased alive on April 19, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Paul G. Ensor - M.D. | | | | 22c. DATE SIGNED 4/19/68 | |
| 22d. PHYSICIAN'S NAME (Type) Paul G. Ensor - M.D. | | | | 22e. ADDRESS Springfield State Hospital, Sykesville | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Stabler's Cemetery | |
| 24. FUNERAL DIRECTOR John Burns Lewis | | 24b. ADDRESS Towson Md. | | 25a. REC'D BY REG. STRAR APR 25 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

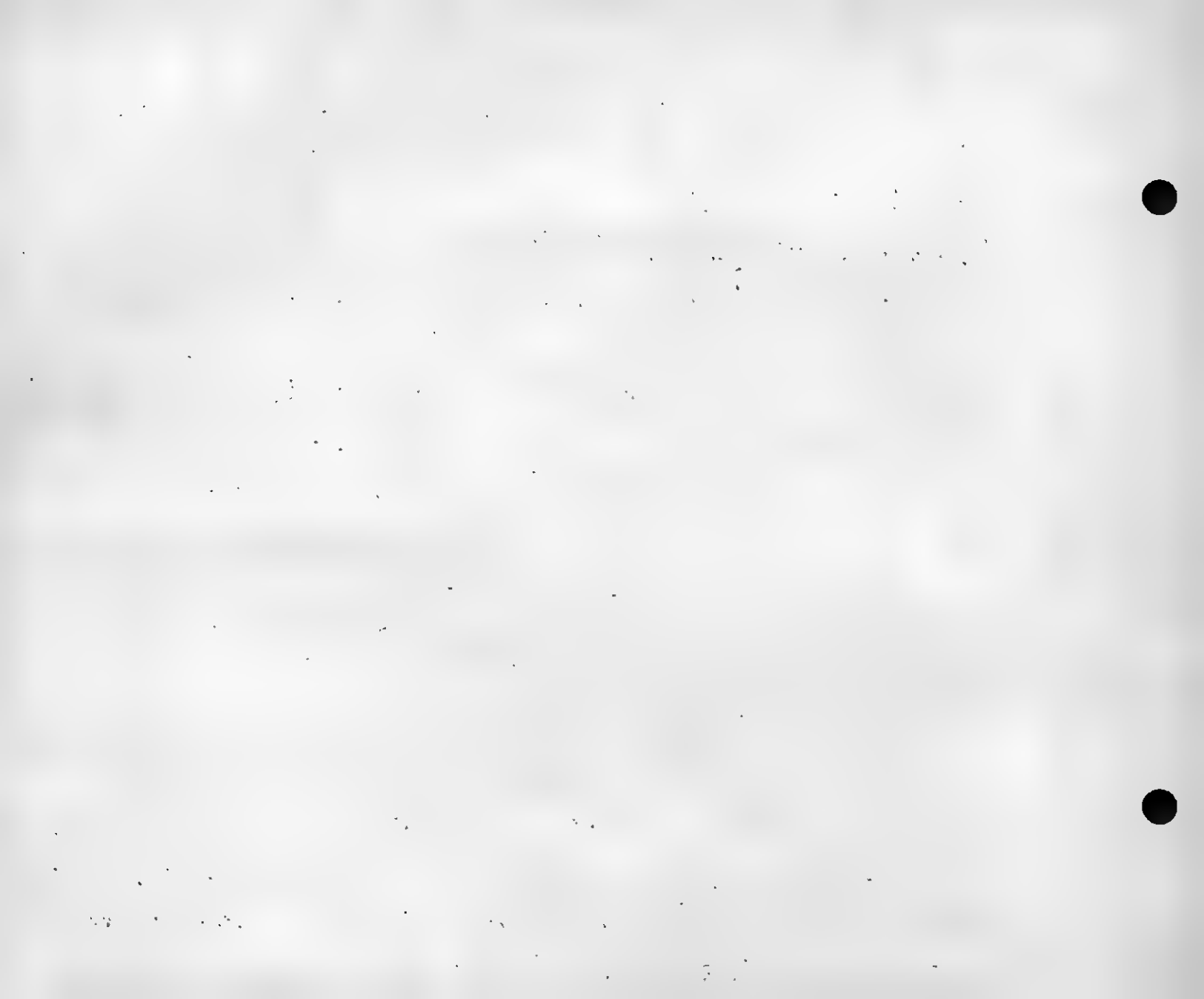


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Sue MAE HENRY | | | 2a. DATE OF DEATH Month Day Year April 9 1968 | | | 2b. HOUR 1:15 PM | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH March 8. 1878 | | 6. AGE (In years lost birthday) 90 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 7. UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Manchester MD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived in institution; Residence before admission) Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Hampstead | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 122 Shiloh Ave | | | |
| 14. FATHER'S NAME First Middle Last Daniel LOWERY | | | 15. MOTHER'S MAIDEN NAME First Middle Last Barbara Ann PIPPER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no | | 16b. SOCIAL SECURITY NO. 212-18-9554 | | 17. INFORMANT Address Mrs. Mattie Miller Hampstead MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Chronic Myocarditis 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 Diabetes mellitus mild | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 9, 1965, to April 9, 1968, that (I) (we) last saw the deceased alive on April 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Joseph E. Bush MD | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/9/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Joseph E. Bush MD | | 22e. ADDRESS Hampstead Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY EMORY METH. CEM. | | 23d. LOCATION (City or Town) (County) (State) HAR CEDERHURST, CARROLL, MD | | | | | |
| 24. FUNERAL DIRECTOR James G. Saffery | | 25a. ADDRESS WESTMINSTER, MD | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE APR 11 1968 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

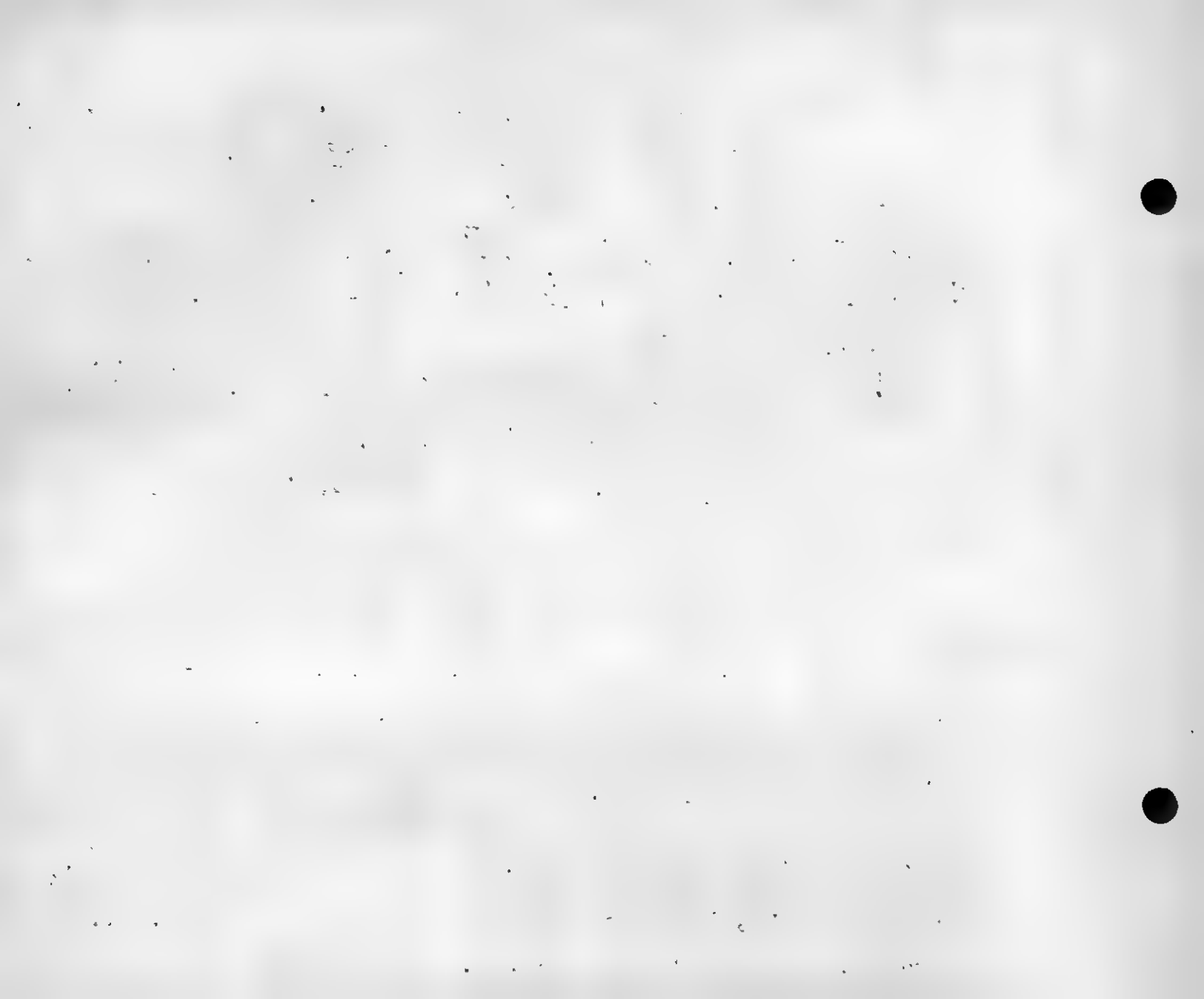
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1544
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2a Film 0401572/18

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) <i>Rachel B. Herb</i> | | | 2a. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1968</i> | | 2b. HOUR <i>4:15</i> P.M. |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>October 15 1887</i> | | 6. AGE (In years last birthday) <i>80</i> YRS. | IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Carroll</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Manchester Md</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Longview nursing home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | 13a. INSURE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET AND NUMBER <i>Route 7</i> | |
| 14. FATHER'S NAME First <i>Alfred</i> Middle <i>Bohner</i> Last <i>Bohner</i> | | 15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>216-03-8420</i> | | 17. INFORMANT Name <i>Robert S. Herb</i> Address <i>RD #4 Westminster Md</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> 4124 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <i>Outset of acute cardiac decompensation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Outset of acute cardiac decompensation</i> DUE TO, OR AS A CONSEQUENCE OF PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 7</i> , 1968, to <i>4-26</i> , 1968, that (I) (we) last saw the deceased alive on <i>4-26</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Joseph E. Bush MD</i> | | 22c. DATE SIGNED <i>1968</i> | | 22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i> | |
| 22e. ADDRESS <i>Hampstead Maryland</i> | | 22f. ADDRESS <i>Hampstead Maryland</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>April 29, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i> | |
| 23d. LOCATION (City or Town) (County) (State) <i>Woodlawn Balto. Md.</i> | | 24. FUNERAL DIRECTOR ADDRESS <i>Tipton - Eline Funeral Home Hampstead, Md.</i> | | | |
| 25a. REC'D BY REGISTRAR DATE <i>APR 30 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) HERBERT C Hill | | | 2a. DATE OF DEATH Month April Day 5 Year 1968 | | | 2b. HOUR 9 A.M. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH April 14 1884 | | 6. AGE (In years last birthday) 83 1/2 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) (?) | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Cerro Hill | |
| 10. CITY OR TOWN OF DEATH Manches | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Longview Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Storekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Grain | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland | | 13b. COUNTY Cerro Hill | | 13c. CITY OR TOWN Sylasville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 1400 W. Main | | 14. FATHER'S NAME First Middle Last Arthur Hill | | 15. MOTHER'S MAIDEN NAME First Middle Last Catherine Stockdale | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 218-32-1253 | | 17. INFORMANT George A. Newburn | | Address Reisterstown Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) One Month | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. 19 P.M. Month March Day 13 Year 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 13, 1968 to April 5, 1968 , that (I) (we) last saw the deceased alive on April 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph E. Bush | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED April 5, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Joseph E. Bush | | 22e. ADDRESS 1400 W. Main | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | | 23b. DATE April 8, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery | | 23d. LOCATION (City or Town) (County) (State) Reisterstown, Md. | |
| 24. FUNERAL DIRECTOR J. F. Eline & Sons | | ADDRESS Reisterstown, Md. | | 25a. REC'D BY REGISTRAR DATE APR 8 - 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



X

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 3 - Klee Mill Road</u> | | | | d. STREET ADDRESS <u>Route 3 - Klee Mill Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LE ROY</u> Middle <u>HIP SLEY</u> Last <u>X</u> | | | | 4. DATE OF DEATH Month <u>4</u> - Day <u>9</u> Year <u>1968</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-26-1890</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>William H. Hipsley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Rauehart</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>220-54-9331</u> | | 17. INFORMANT <u>Mrs Jane J. Hipsley</u> Address # <u>3</u> <u>Sykesville Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Prostate Hypertrophy</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u> <u>2-3 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-4</u> , 19 <u>64</u> , to <u>4-9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-7</u> , 19 <u>68</u> , and that death occurred at <u>8:45</u> AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>W. L. Schumacher</u> | | | | 22b. DATE SIGNED <u>4-9-68</u> | | 22c. PHYSICIAN'S NAME (Type) <u>W. L. Schumacher, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>4/13/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lanham Park</u> | | 23d. LOCATION (City, town or county) (State) <u>Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Loring Byers - 8728 Liberty Road</u> | | | | 25a. REC'D BY REGISTRAR <u>APR 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |



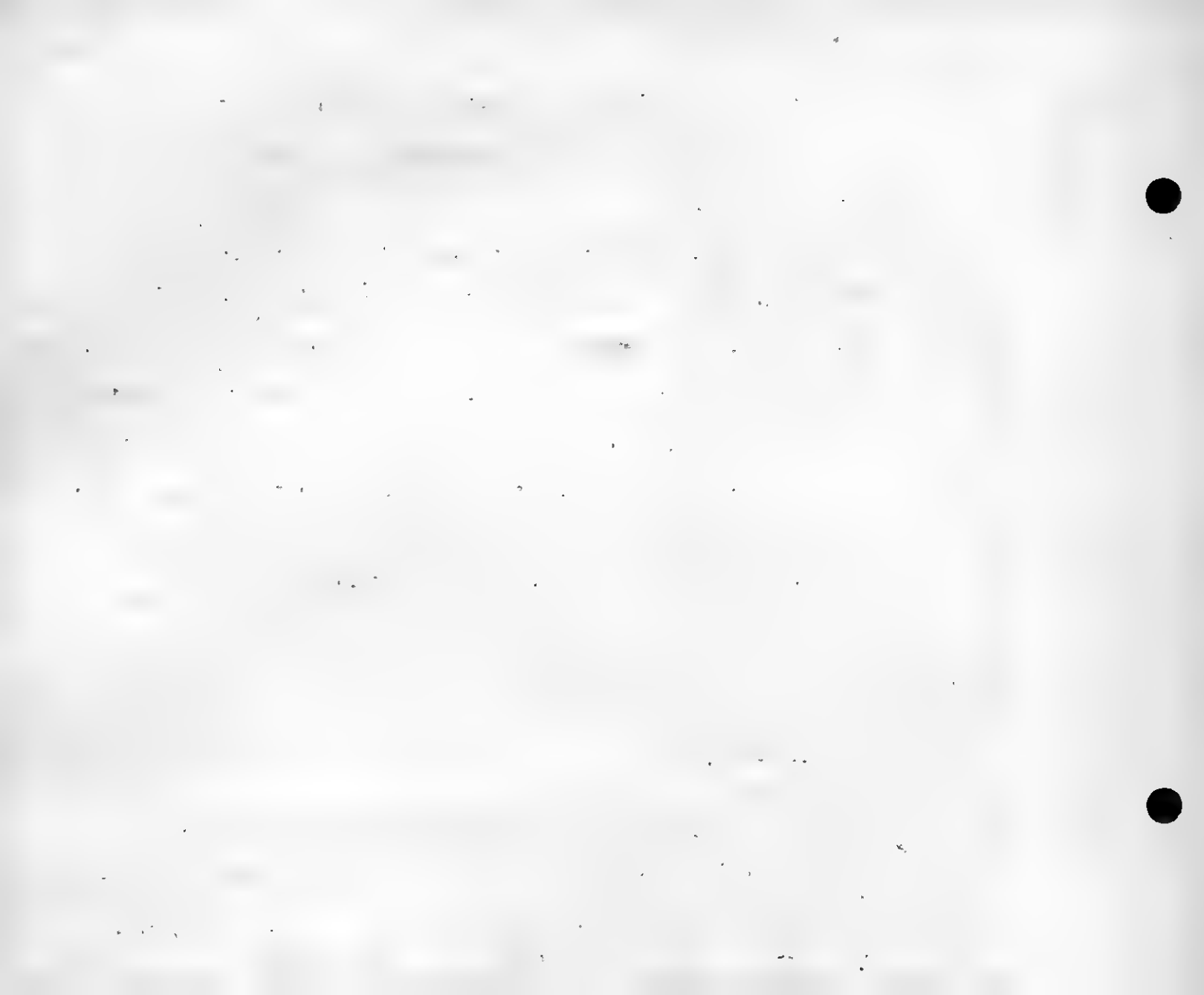
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) LOUIS | | | First Middle Last LOUIS (NMN) JENKINS | | | 2a. DATE OF DEATH Month Day Year APRIL 24, 1968 | | | 2b. HOUR P 1:30 M | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 3-14-1880 | | | 6. AGE (In years last birthday) 88 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Carroll Md. | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer (retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY FARM | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Allegany | | | 13c. CITY OR TOWN Cumberland | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last John R. Jenkins | | | 15. MOTHER'S MAIDEN NAME First Middle Last Margaret Shokley | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 212-12-8815 | | |
| 17. INFORMANT Records, Springfield State Hospital | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Aortic valve stenosis with myocardial hypertrophy DUE TO, OR AS A CONSEQUENCE OF (c) 411 X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS assoc. with senile brain disease, without qualifying phrase | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-14-68 , 19__, to 4-24-68 , 19__, that (I) (we) last saw the deceased alive on 4-24-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Octavio A. Ruiz</i> | | | DEGREE Octavio A. Ruiz, M. D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 4-24-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D. | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE APRIL 27, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEM. | | | 23d. LOCATION (City or Town) (County) (State) CUMBERLAND MD. | | |
| 24. FUNERAL DIRECTOR BYRON KIGHT | | | ADDRESS CUMBERLAND MD. | | | 25a. REC'D BY REGISTRAR DATE APR 29 1968 | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |



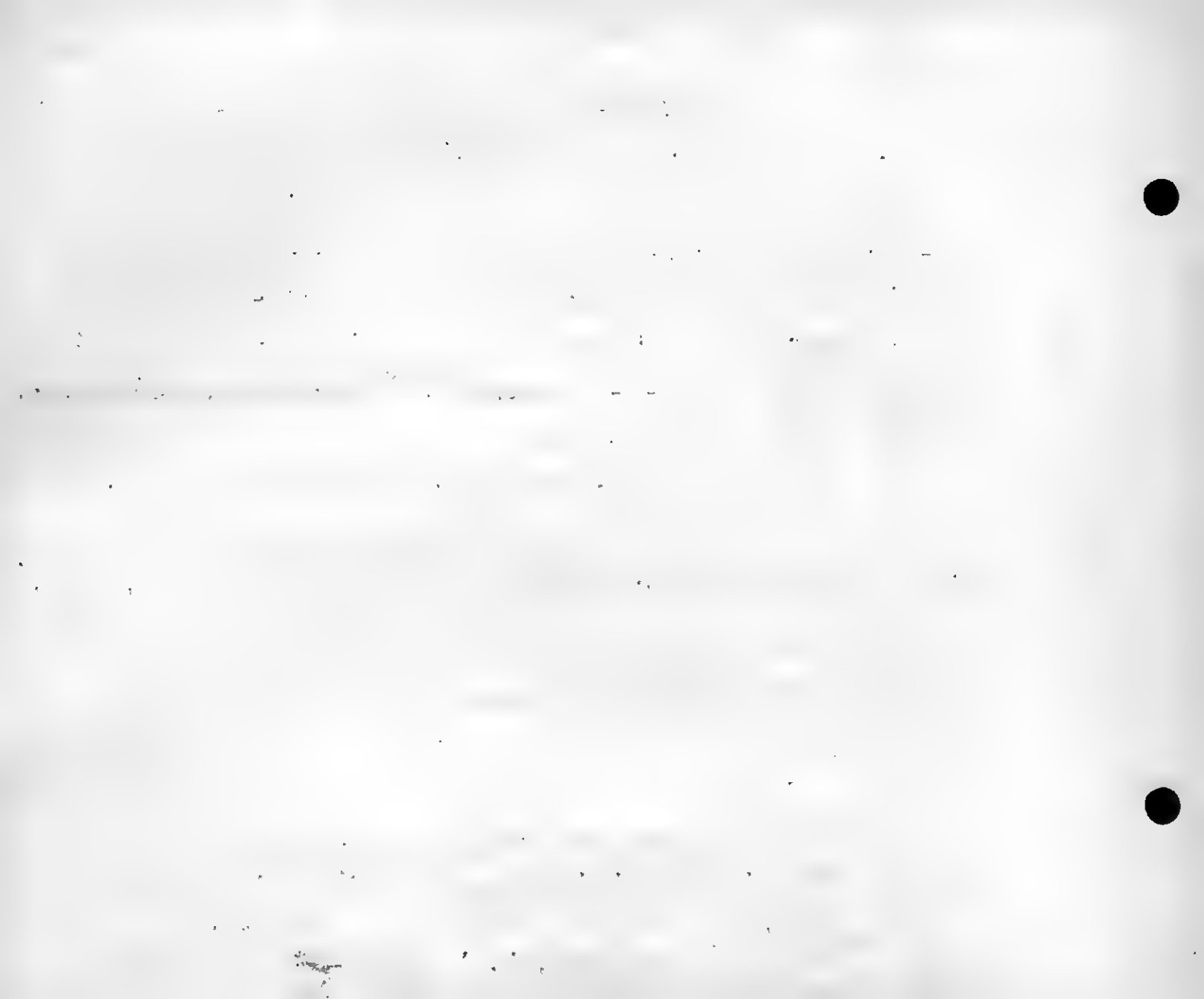
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) Ivy Winifred Johnson | | | 2a. DATE OF DEATH 4 Month 24 Day 68 Year | | | 2b. HOUR 10:20 am | | | | | |
| 3 SEX female | | 4 RACE white | | 5. DATE OF BIRTH 4/16/99 | | 6 AGE (in years last birthday) 69 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) England | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Carroll | | | | | |
| 10. CITY OR TOWN OF DEATH Rural--Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 3203 Echodale Avenue | | |
| 14. FATHER'S NAME First Middle Last Arthur Arthur Limbrick | | | 15. MOTHER'S MAIDEN NAME First Middle Last Catherine - ? | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service) no | | | 16b. SOCIAL SECURITY NO. 214-18-3433 | | 17. INFORMANT Frederick A Johnson | | | Address Same | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4335 (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic/ | | | | | | | | | reaction. | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/23/1965 , to 4/24/1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 4/24/1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Renato R. Espina, M.D. | | | | | 22c. DATE SIGNED 4/24/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D. | | | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md | | | | |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc | | | | | ADDRESS Balto, Md. | | | 25a. REC'D BY REGISTRAR APR 25 1968 | | 25b. REGISTRAR'S SIGNATURE William Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | CERTIFICATE OF DEATH | | | |
|---|--|--|---|---|--|---|--|
| Item 13 Film G399 4/22/68 kkk | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>MARGARET RUTH KIRAN</u> | | | 2a. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1968</u> | | | 2b. HOUR M | |
| 3. SEX <u>FEMALE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH <u>OCT 14, 1894</u> | | 6. AGE (In years last birthday) <u>73</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <u>PHILA PA</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>CARROLL</u> Md. | |
| 10. CITY OR TOWN OF DEATH <u>SYKESVILLE</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>GRAND VIEW NURSING HOME</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>AT HOME</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>SYKESVILLE MD</u> | | 13b. COUNTY <u>CARROLL</u> | | 13c. CITY OR TOWN <u>SYKESVILLE</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First <u>J. WESLEY</u> Middle <u>HILL</u> Last <u>SINGER</u> | | 15. MOTHER'S MAIDEN NAME First <u>MARGARET</u> Middle <u>C</u> Last <u>KRAFT</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT Address <u>JACOB KIRAN, Oakwood Mill Rd, ELICOTT CITY MD</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia - fibrinous - hypostatic</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocarditis - Chronic Decompensated</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis - general</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <u>4. + 1</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>24 hours</u> <u>off</u> | | | |
| 19a. DATE OF OPERATION <u>✓</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>✓</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>✓</u> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) <u>✓</u> | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>✓</u> | | 21f. LOCATION Street or R.F.D. No. City or Town County State <u>✓</u> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1-1968</u> to <u>4-4-1968</u> , that (I) (we) last saw the deceased alive on <u>4-2-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>James B. Saffell</u> | | DEGREE <u>M.D.</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>4-5-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>James B. Saffell M.D.</u> | | 22e. ADDRESS <u>Reisterstown, Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 23b. DATE <u>4-5-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>J.W.M. LEE</u> | | 23d. LOCATION (City or Town) (County) (State) <u>NASHINGTON, D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>John R. Black, Ellicott City Md</u> | | ADDRESS <u>---</u> | | 25a. REC'D BY REGISTRAR <u>---</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>ADD 15 1968</u> | | | | | | | |



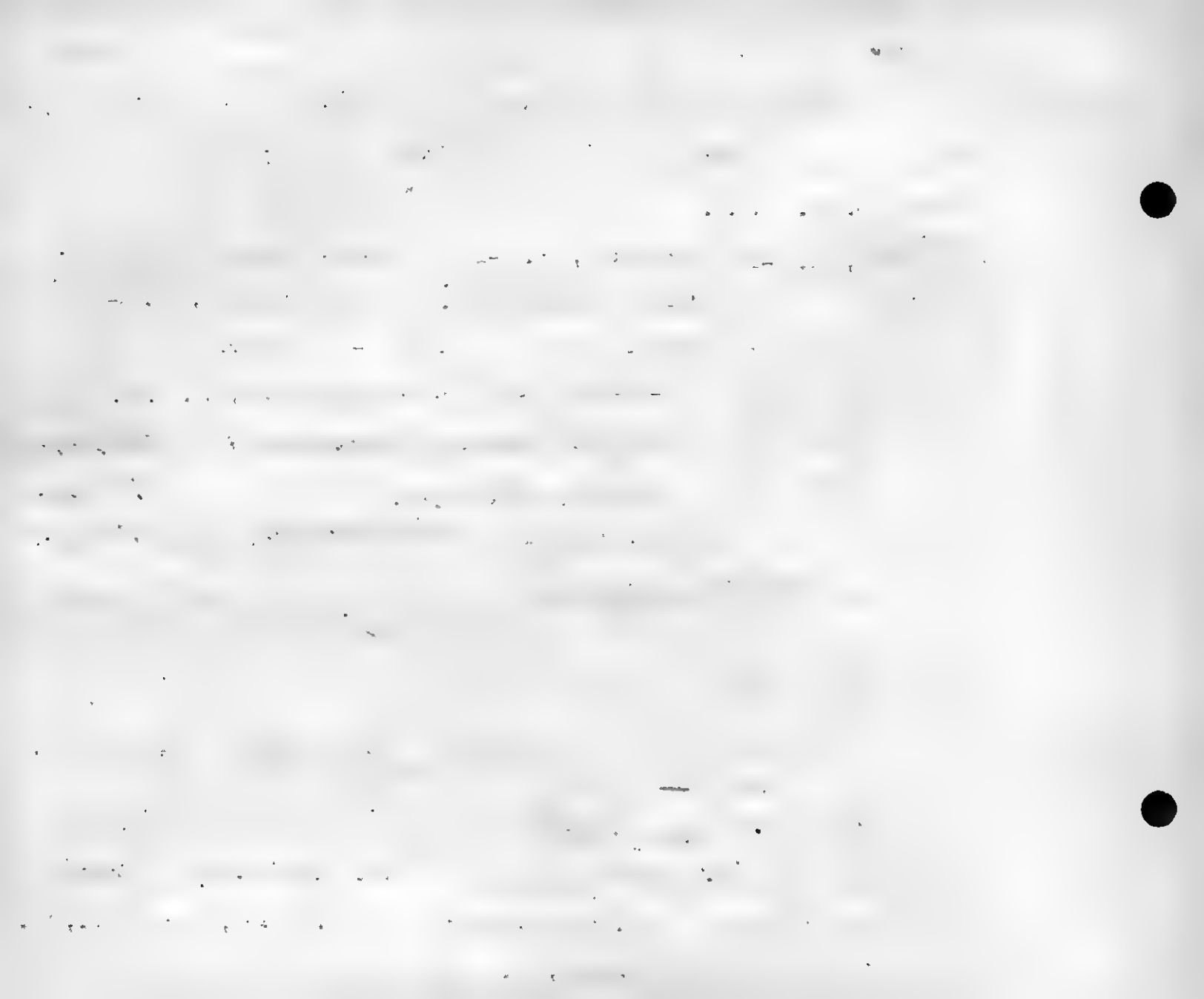
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AL 15
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|--|---|---|--|--|--|------------------------------------|--|
| 1. DECEASED NAME (Type or print) Washington Peter Koontz | | | 2a. DATE OF DEATH April Month 16 Day 68 Year | | | 2b. HOUR 10 P.M. | | | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH 9/18/1895 | | 6. AGE (In years last birthday) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) Carroll Co., Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Mailing Address Littlestown, Pa. R-1 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Littlestown, Pa. R-1 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foundry Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Foundry | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Mailing Add. Littlestown | | 13d. INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Mailing Address Littlestown, Pa. R-1 | | | |
| 14. FATHER'S NAME First Middle Last Nelson - Koontz | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ida - Reinaman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) No | | | 16b. SOCIAL SECURITY NO. 212-14-6956 | | 17 INFORMANT Address Robert S. Fitz, Taneytown, Md. R. D. 1 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intense Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Deteriorated Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral Arteriosclerosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Minutes 15 yrs. 20 yrs. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/9 , 19 40 , to 4/16 , 19 68 , that (I) (we) last saw the deceased alive on 4/9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | 22b. SIGNATURE R. S. McVaugh M.D. | | 22c. DATE SIGNED 4/17/68 | |
| 22d. PHYSICIAN'S NAME (Type) R. S. McVaugh | | 22e. ADDRESS Taneytown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | 23d. LOCATION (City or Town) (County) (State) Silver Run, Carroll Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR Richard A. Little | | | | ADDRESS Littlestown, Pa. | | 25a. REC'D BY REGISTRAR DATE APR 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (Type or print) <u>Beeba V. LARGENT</u> | | | 2a DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>68</u> | | | 2b HOUR <u>10²⁵</u> A M | |
| 3. SEX <u>FEMALE</u> | | 4 RACE <u>WHITE</u> | | 5. DATE OF BIRTH <u>JULY 1 1885</u> | | 6. AGE (In years last birthday) <u>82</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <u>W. VA</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>CARROLL</u> | |
| 10. CITY OR TOWN OF DEATH <u>WESTMINSTER</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>CARROLL CO. GENERAL HOSP</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>AT home</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <u>MD</u> | | 13b. COUNTY <u>CARROLL</u> | | 13c. CITY OR TOWN <u>Woodbine</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER <u>(Rural) R.F.D. #1</u> | | 14. FATHER'S NAME First <u>Cyrus</u> Middle <u>WISNER</u> Last <u>ADA</u> | | 15. MOTHER'S MAIDEN NAME First <u>Harley</u> Middle <u>WOODBINE</u> Last <u>MARYLAND</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <u>215-50-5828</u> | | 17. INFORMANT <u>MRS GEORGE WILDER</u> | | Address <u>WOODBINE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>WEEKS</u> <u>YEARS</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4120</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>68</u> , to <u>4/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Vincent J. Krosch</u> | | DEGREE <u></u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>4/4/68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u></u> | | 22e. ADDRESS <u></u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>4-7-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MT Nebo</u> | | 23d. LOCATION (City or Town) (County) (State) <u>MORGAN COUNTY W. VA.</u> | |
| 24. FUNERAL DIRECTOR <u>John R. Stack</u> | | ADDRESS <u>Ellicott City, Md.</u> | | 25a. REC'D BY REGISTRAR <u>APR 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



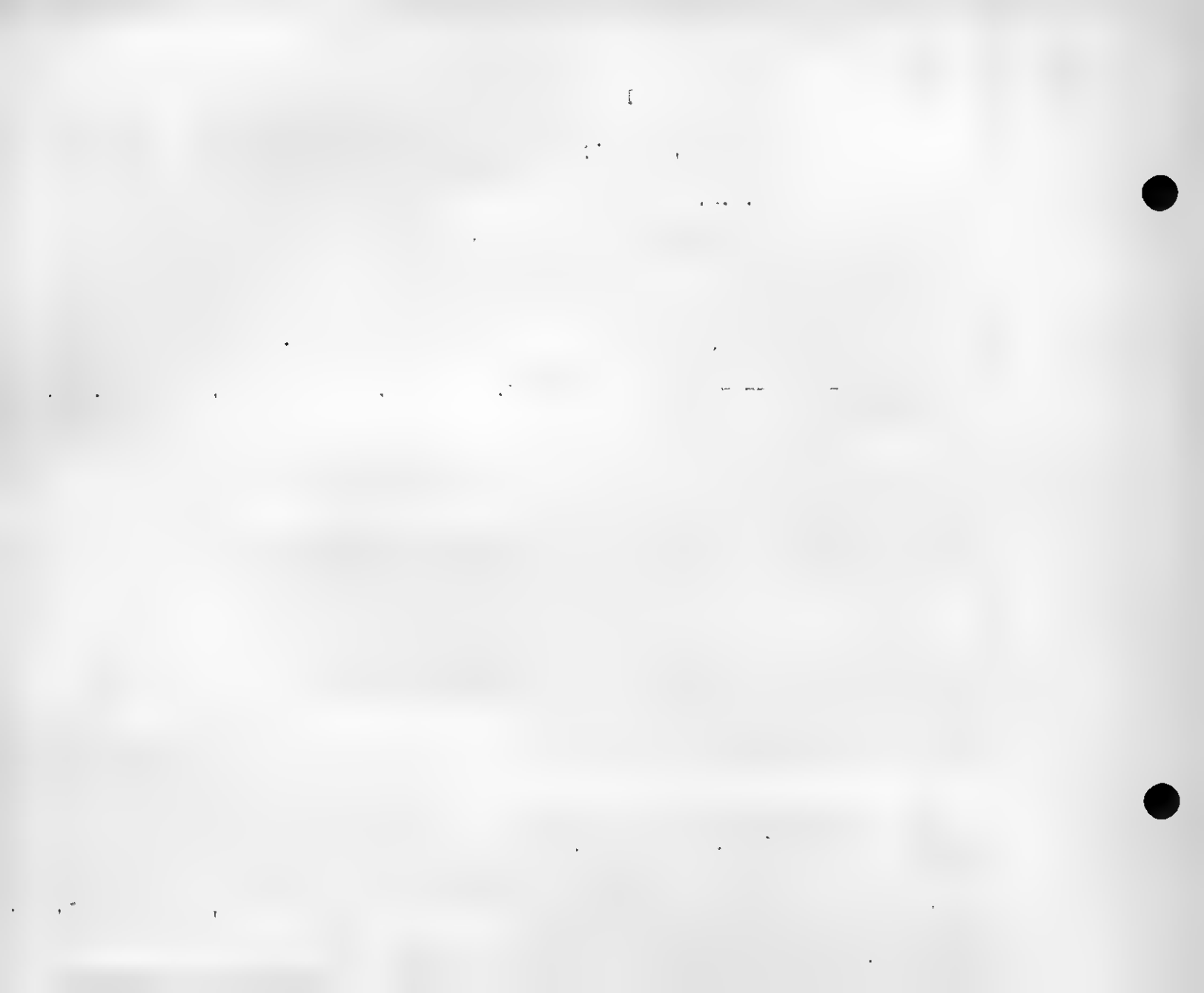
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1 DECEASED-NAME (Type or Print) MARY | | First | | Middle Elizabeth | | Last MASSER | | 2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH July 26, 1905 | | 6 AGE (In years last birthday) 62 RS. | | 2c DATE PRONOUNCED DEAD Month April 6, Year 1968 2a HOUR 10:15 MIN PM | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | | Md | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Fredrick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5th Street | |
| 14. FATHER'S NAME First Charles Middle H. Last Masser | | 15. MOTHER'S MAIDEN NAME First Ada Middle T. Last Kreh | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO None | | 17 INFORMANT ADDRESS Mrs. Howard T. Dinterman Rt. # 10 Fred. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Epileptic Seizure 3459 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum | | EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED 4-8-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery | | 23d. LOCATION (City or Town) Frederick, Md. | | (County) (State) | |
| 24. FUNERAL DIRECTOR Robert E. Dailey & Son | | ADDRESS Frederick, Maryland | | 25a. REC'D BY REGISTRAR APR 11 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

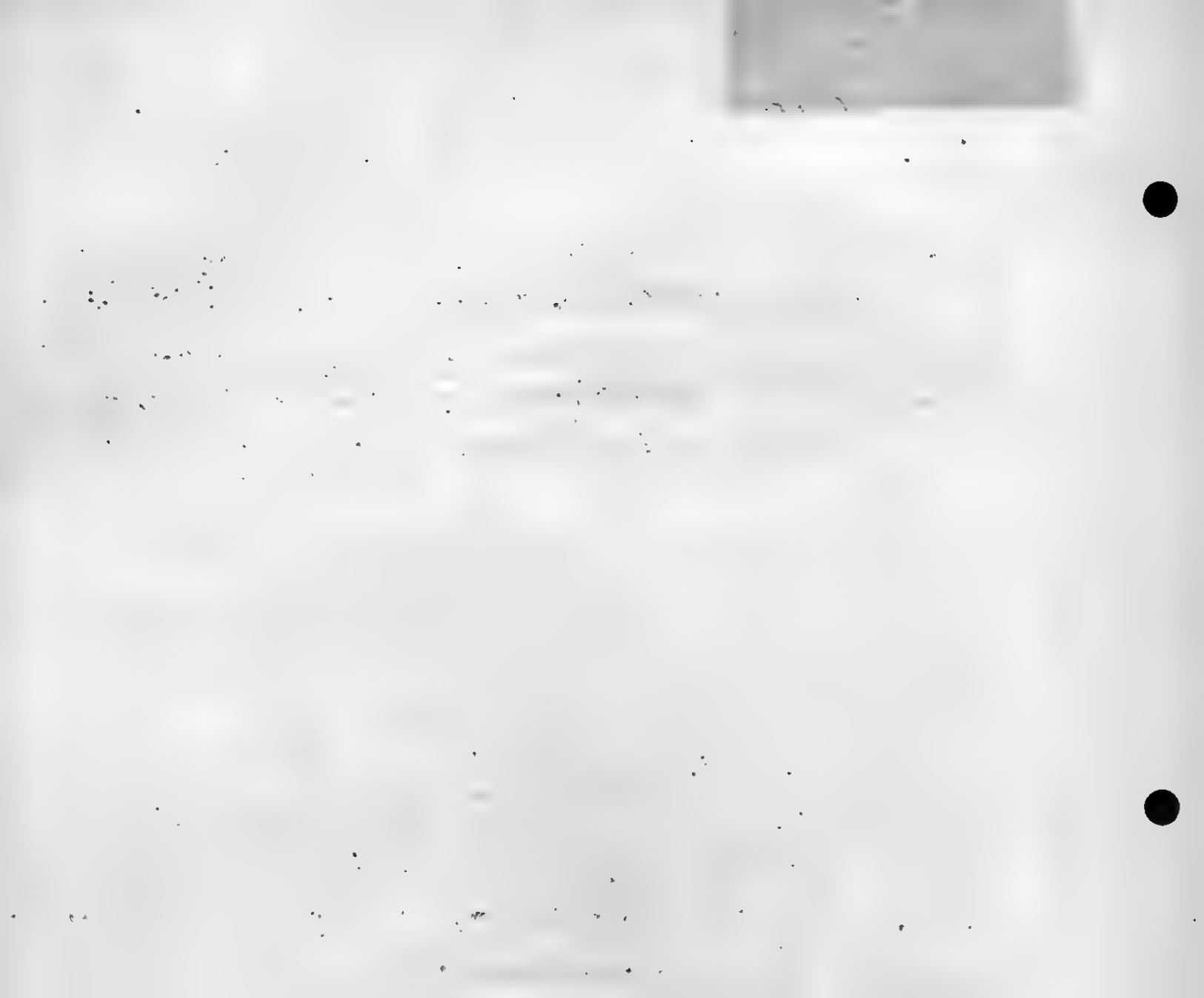


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|------------------------------------|---|--|--|---|
| 1. DECEASED NAME (Type or print) CARRIO S MATHIAS | | | 2a. DATE OF DEATH April 10 1968 | | | 2b. HOUR 12:45 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 4/12/1876 | | 6. AGE (In years last birthday) 91 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) USA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | |
| 10. CITY OR TOWN OF DEATH Manchester | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. STREET AND NUMBER 2910 Manhattan Ave. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME Itor Ace | | 15. MOTHER'S MAIDEN NAME Sylvania Saunders | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. 220-44-8225 | | 17. INFORMANT Robert B Mathias | | Address Baltimore, Md 21212 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac Vascular Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/29 , 19 68 , to 4/10 , 19 68 , that (I) (we) last saw the deceased alive on 4/8 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W.H. Ford M.D. | | DEGREE M.D. | | ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) W.H. Ford M.D. | | 22c. DATE SIGNED 4/10/68 | | | | | |
| 22e. ADDRESS Manchester, Md 21102 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION (City or Town) (County) (State) Manchester, York Co., Pa. | |
| 24. FUNERAL DIRECTOR H.J. Eichhardt | | ADDRESS Owings Mills, Maryland | | 25a. REC'D BY REGISTRAR APR 15 1968 | | 25b. REGISTRAR'S SIGNATURE J. Edgar Judge | |



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Susan Kathryn McNeal | | | 2a. DATE OF DEATH Month April Day 20 Year 1968 | | | 2b. HOUR 9:15 AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH April 2, 1896 | | 6. AGE (In years last birthday) 72 YRS. | | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 2405 Pennsylvania Avenue | |
| 14. FATHER'S NAME First Middle Last Frank - Zimmerman | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary -- Black | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO 219-20-3717 | | 17. INFORMANT Address Springfield Hospital records, Sykesville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC FAILURE 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) 24 hrs 24 hrs | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CBS associated with cerebral arteriosclerosis with behavioral reaction | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 13, 1967 , to Apr. 20, 1968 , that (X) (we) last saw the deceased alive on Apr. 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Naci Bayukunsal, M.D. | | | | 22c. DATE SIGNED Apr. 20, 1968 | | 22d. PHYSICIAN'S NAME (Type) Naci Bayukunsal, M.D. | | | |
| 23a. BURIAL, CREMATION, or other disposition BURIAL | | 23b. DATE 4-23-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR DATE APR 23 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

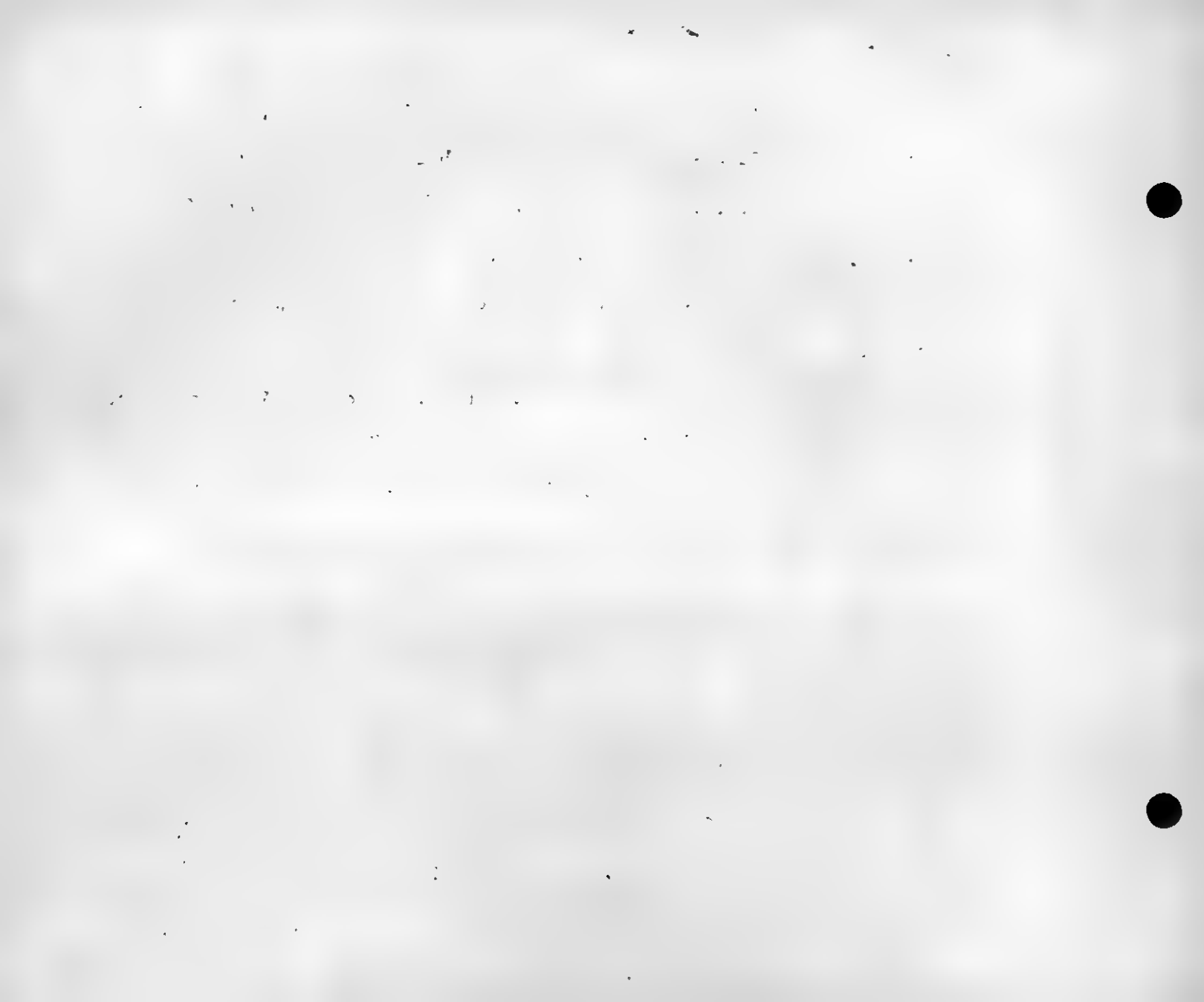
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VR 1514
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (Type or print) <i>Katherine Kness Moore</i> | | | 20. DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1968</i> | | | 2b. HOUR <i>8:15 P M</i> | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH <i>March 11, 1871</i> | | 6. AGE (In years last birthday) <i>97</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Carroll</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Mt. Airy</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Twinarch Rd.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>No</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>3557 Greenmount Ave.</i> | |
| 14. FATHER'S NAME First Middle Last <i>John Kness</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>El Keil</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) <i>No</i> | | 16b. SOCIAL SECURITY NO <i>218-54-3997</i> | | 17. INFORMANT Address <i>Mr. John C. Moore-son 3557 Greenmount Ave. 212</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>"</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Many years</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>42+</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 1967, to <i>April</i> , 1968, that (I) (we) last saw the deceased alive on <i>April 16</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>W.B. Culwell M.D.</i> | | | | 22c. DATE SIGNED <i>April 16, 1968</i> | | 22d. PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>4/19/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Louder Park Cem</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i> | | 23e. REC'D BY REGISTRAR DATE <i>APR 19 1968</i> | |
| 24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</i> | | | | 24b. ADDRESS | | 24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

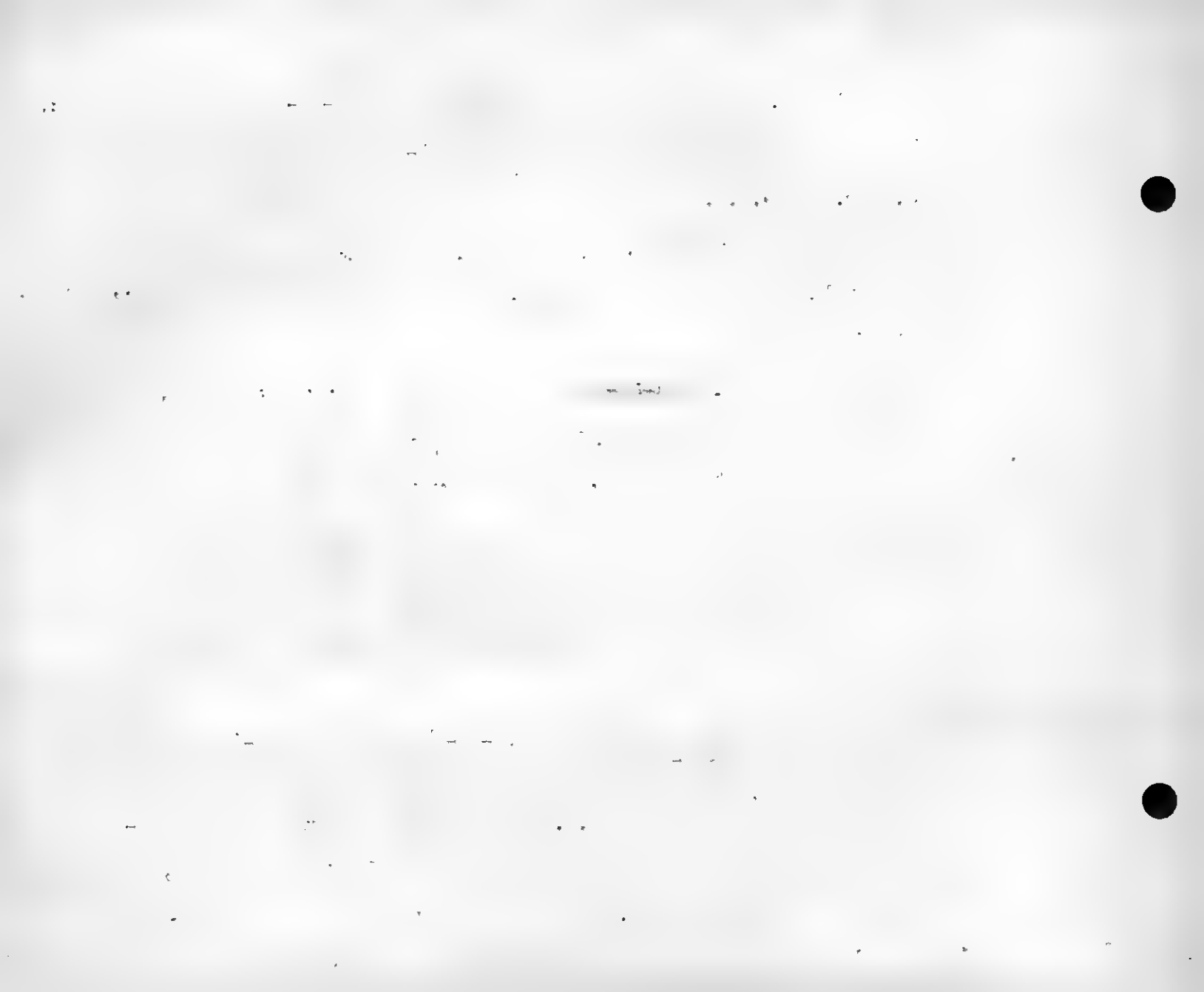
MEDICAL CERTIFICATION



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|---------------------------------------|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last William Moten | | | | | | 2a. DATE OF DEATH Month Day Year 4-19-68 | | | 2b. HOUR 8:20AM | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH 3-19-75 | | 6. AGE (In years last birthday) 93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) S. Car. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | | | Md | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3825 Cottage Ave., Balt 15 | | |
| 14. FATHER'S NAME First Middle Last Bennie Moten | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no | | | | 16b. SOCIAL SECURITY NO 251-20-3197 | | 17. INFORMANT Address Records, Springfield State Hosp. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Left sided hemiplegia (old) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. no. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-12-64 , 19__, to 4-19-68 , 19__, that (I) (we) last saw the deceased, alive on 4-19-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Ernest Beiser | | | | M.D. DEGREE Ernest Beiser | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4-19-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Ernest Beiser | | | | 22e. ADDRESS Springfield State Hospital, Sykesville | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 4/27/68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR Elmer E. Budnik | | | | ADDRESS 218-14 E. North Ave. Baltimore Md 21202 | | 25a. REC'D BY REGISTRAR DATE APR 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



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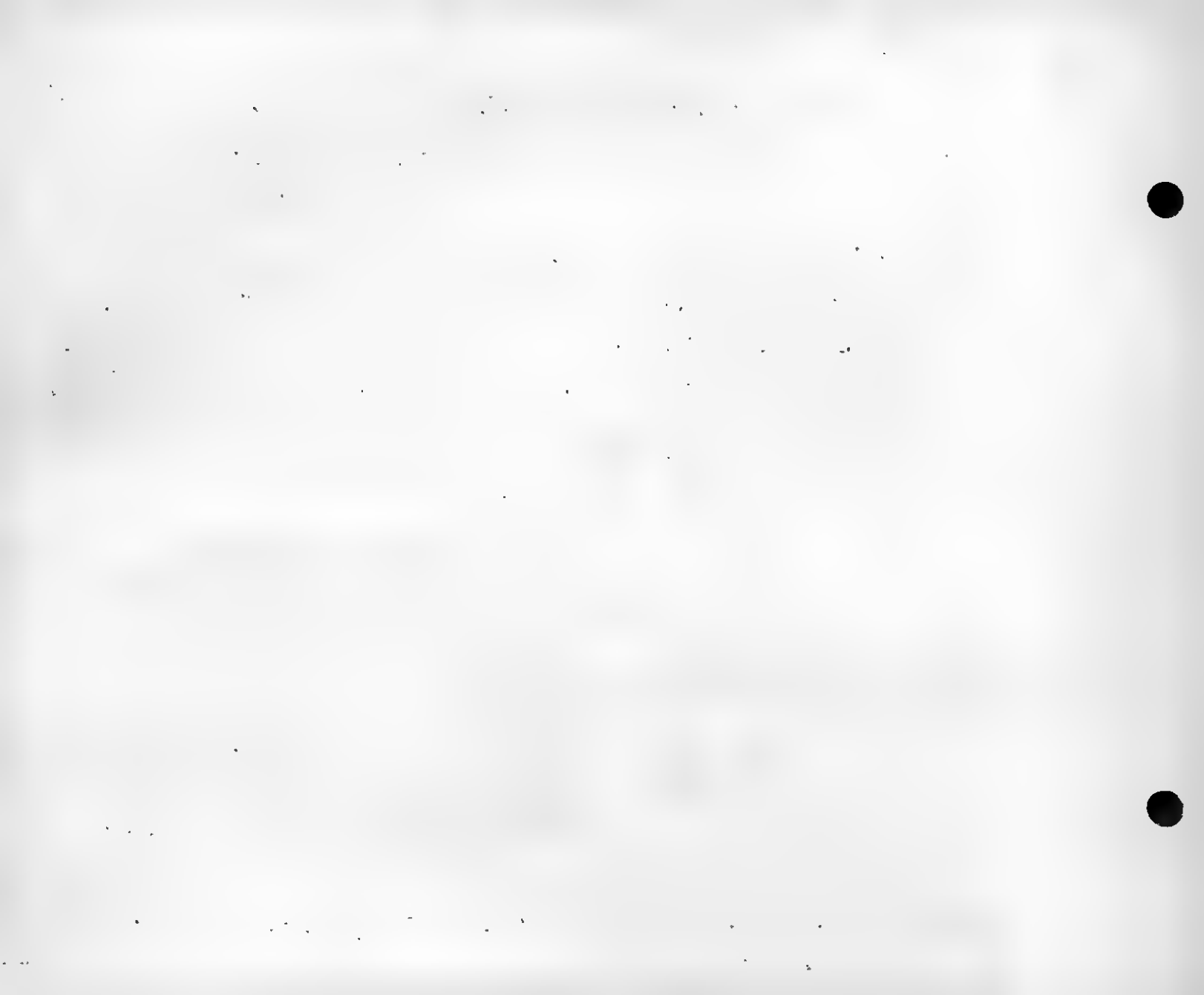
| MARTIN LUTHER KING, JR. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|---|---------------------------------|--|
| 1. DECEASED-NAME (Type or print) First: PAUL Middle: JACOB Last: MYERLY | | | | | | 2a. DATE OF DEATH Month: APRIL Day: 14, Year: 1968 | | | 2b. HOUR 8:45 P M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 10-2-1884 | | 6. AGE (In years last birthday) 83 YRS. | | 7. UNDER 1 YEAR MONTHS: DAYS: HOURS: M.N. | | IF UNDER 24 HRS. HOURS: M.N. | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer (retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Carroll | | 13. CITY OR TOWN Manchester | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET AND NUMBER 5 Westminster St. | | |
| 14. FATHER'S NAME First: John Middle: T. Last: Myerly | | | 15. MOTHER'S MAIDEN NAME First: Joanne Middle: Baker Last: Unk. | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 214-36-7599 | | 17. INFORMANT Address: Records, Springfield State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable ruptured aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>330X</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CBS assoc. with senile brain disease, with psychotic reaction</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-13-67</u> , 19 <u> </u> , to <u>4-14-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4-14-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Octavio A. Ruiz M.D.</u> DEGREE 22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D. | | | | | | 22c. DATE SIGNED 4-15-68 | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-18-1968 | | 23c. NAME OF CEMETERY OR CREMATORY St. David's Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hampden York Md | | | | | |
| 24. FUNERAL DIRECTOR Tepton Eline Hampstead, Maryland. | | | | | | 25a. REC'D BY REGISTRAR DATE APR 18 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

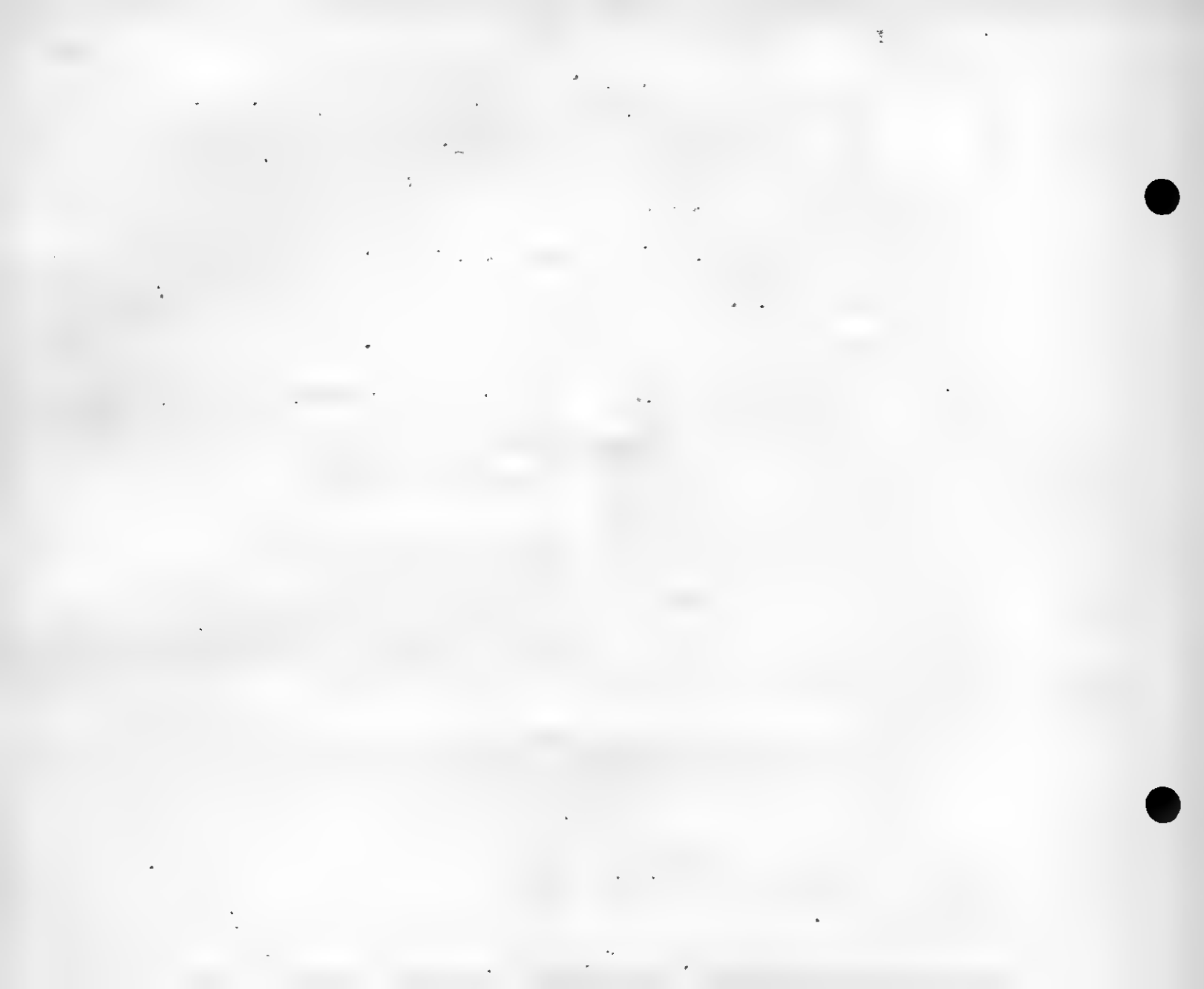
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last PAUL CHARLES NESS | | | | | | 2a. DATE OF DEATH Month Day Year 4 20 68 | | | 2b. HOUR-MIN 3 45 A M | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH OCT. 23 1907 | | | 6. AGE (In years last birthday) 60 YRS. | | IF UNDER YEAR MONTHS DAYS 12 12 12 | | IF UNDER 24 HRS. HOURS MIN. 12 12 12 | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH CARROLL CO. Md | | | | | | |
| 10. CITY OR TOWN OF DEATH WESTMINSTER | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) CARROLL CO. GEN. HOSPT. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER | | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN WESTMINSTER | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER RFD #5 Box 136 | | | |
| 14. FATHER'S NAME First Middle Last JACOB EDWARD NESS | | | | 15. MOTHER'S MAIDEN NAME First Middle Last LUCY A. WALSH | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO 212-32-4855 | | 17. INFORMANT MRS EDNA WATZ NESS | | | Address SAME ADDRESS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) - | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) T | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) - | | 21b. TIME OF INJURY HOUR A.M. Month Day Year - | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) - | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> - | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING, ETC) - | | 21f. LOCATION Street or RFD No. City or Town County State - | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/16 , 19 68 , to 4/20 , 19 68 , that (I) (we) last saw the deceased alive on 4/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | |
| 22b. SIGNATURE Vincent J. Kucera Jr M.D. | | | | | | 22c. DATE SIGNED 4/20/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) - | | | | | | 22e. ADDRESS - | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEMETERY | | 23d. LOCATION (City or Town) (County) (State) WESTMINSTER CARROLL MD | | | | | | |
| 24. FUNERAL DIRECTOR J. E. Myers Jr, Westminster, Md. | | | | | | 25a. REC'D BY REGISTRAR - | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | |
| DATE APR 23 1968 | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|-------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last ELEANOR JOSEPHINE NITSCH | | | | | | 2a. DATE OF DEATH Month Day Year April 26, 1968 | | | 2b. HOUR A M 10:40 | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 10-9-07 | | 6. AGE (in years last birthday) 60 | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework | | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 4404 Adelle Terrace | | |
| 14. FATHER'S NAME First Middle Last Roman C. Nitsch | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Loretta Moore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. Unk. | | 17. INFORMANT Address Records, Springfield State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Papillary adenocarcinoma of 153.8 DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis of carcinoma to omentum and DUE TO, OR AS A CONSEQUENCE OF (c) Serosa of intestines Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 153.8 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-8-46 , 19____, to 4-26-68 , 19____, that (I) (we) last saw the deceased alive on 4-26-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Antonius Glahn | | | | | | 22c. DATE SIGNED 4-26-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D. | | | | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 4-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY Catholick Cem. | | 23d. LOCATION (City or Town) | | (County) | | (State) Md. | |
| 24. FUNERAL DIRECTOR James Cavanaugh | | | | | | 25a. REC'D BY REGISTRAR DATE MAY 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

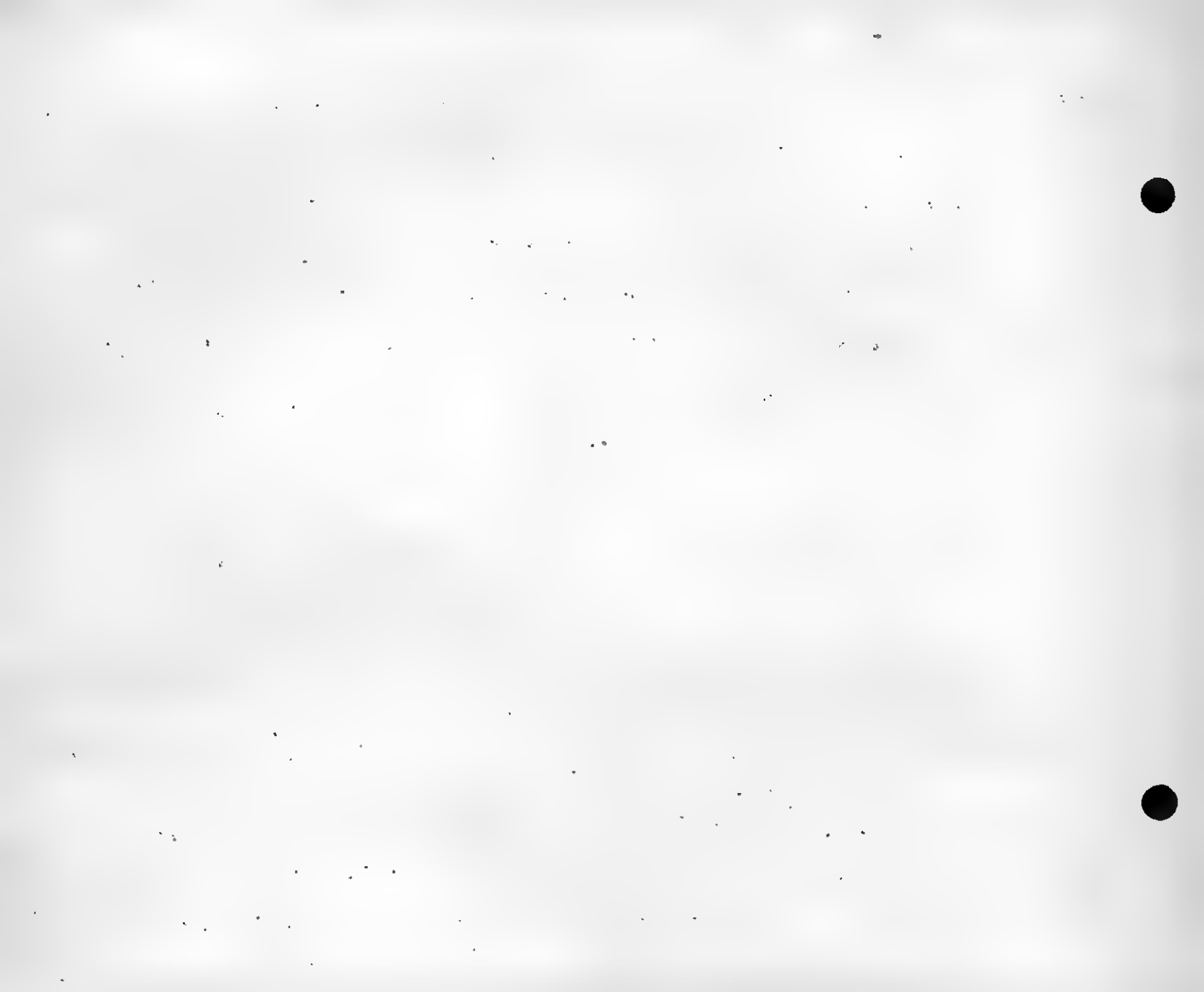
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1 DECEASED-NAME (Type or print) ANNIE M. PETRY | | | 2a. DATE OF DEATH Month April Day 23 Year 1968 | | | 2b. HOUR 8:15 P. M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 1-5-86 | | 6. AGE (In years lost birthday) 82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Md (Carmelle) | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | |
| 10. CITY OR TOWN OF DEATH Manchester | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Manassas Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Westminster | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER RFD-7 | | 14. FATHER'S NAME First Edward Middle Geiman Last Aisenta | | 15. MOTHER'S MAIDEN NAME First Bonbert Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 212-32-323 | | 17. INFORMANT Mrs Andrew Hoy | | Address Bx 282 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 457 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 68 , to 4/23 , 19 68 , that (I) (we) last saw the deceased alive on 4/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W H Foard | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/23/68 | |
| 22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D. | | | | 22e. ADDRESS Manchester, Md 21102 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 4/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM - WESTMINSTER CARROLL MD | | 23d. LOCATION (City or Town) (County) (State) Westminster, Md | |
| 24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md. | | | | 25a. REC'D BY REGISTRAR DATE APR 29 1968 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | |

05498

05501



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film 6400

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1 DECEASED-NAME (Type or print) PEARL First M. Middle PHILLIPS Last | | | 2a. DATE OF DEATH Month 4 Day 26 Year 68 | | | 2b. HOUR 8:45 P M | |
| 3. SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH 6-2-1890 | | 6 AGE (In years last birthday) 77 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) W VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH CARROLL Md. | |
| 10 CITY OR TOWN OF DEATH SYKESVILLE | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PULLEN NSG. HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 1814 Chilton St. | | 14. FATHER'S NAME First Unk. Middle Unk. Last Unk. | | 15. MOTHER'S MAIDEN NAME First Unk. Middle Unk. Last Unk. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 232-10-0388 | | 17 INFORMANT Pullen Nursing Home - Sykesville, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Wreck - Car. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-4 hr. 10 yrs. 5 yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Long. Atherosclerosis, Heart. High Rt. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-22-1967 to 4-26-1968 , that (I) (we) last saw the deceased alive on 4-26-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Sani Okutman | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4-26-68 | |
| 22d. PHYSICIAN'S NAME (Type) Sani Okutman | | 22e. ADDRESS Sykesville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-29-68 | | 23c. NAME OF CEMETERY OR CREMATORY Elkins Cemetery | | 23d. LOCATION (City or Town) (County) (State) Elkins W. VA | |
| 24. FUNERAL DIRECTOR Harry W. Haight | | ADDRESS Sykesville, Md. | | 25a. REC'D BY REGISTRAR DATE APR 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Young | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--------|--|--|--|--|--|--|------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| JAMES ALFRED POOLE | | | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 9:00 PM | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS HOURS | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| M | W | 1-17-29 | 39 YRS | | | MONTH DAY YEAR | | 10:00 AM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Carroll | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Taneytown | | | R.F.D. # 1 | | | Farmer | | Farming | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution-Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | |
| Maryland | | | Carroll | | Taneytown | | R.F.D. #1 | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Charles Wade Peole | | | Edna Beall | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 220-26-4903 | | Charles W. Peole, Sr. Taneytown, Md. R # 1 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line by (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest (myocardial infarction) Sudden | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 823.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | 9:00 AM 4-16-1968 | | Tractor upset on him | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| Farm | | Farm | | Rt 1 Taneytown | | Carroll | | Md | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 4-16-68 | | | |
| W. Glenn Speicher, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS Street, City and/or County | | | |
| | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | | 4/18/1968 | | Beallsville Cemetery | | Beallsville, Montgomery, Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REG. STRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| John H. Skiles | | | DATE APR 18 1968 | | | Charles Judge | | | |
| C.O. Fuss & Son | | | Taneytown, Maryland | | | | | | |



CERTIFICATE OF DEATH

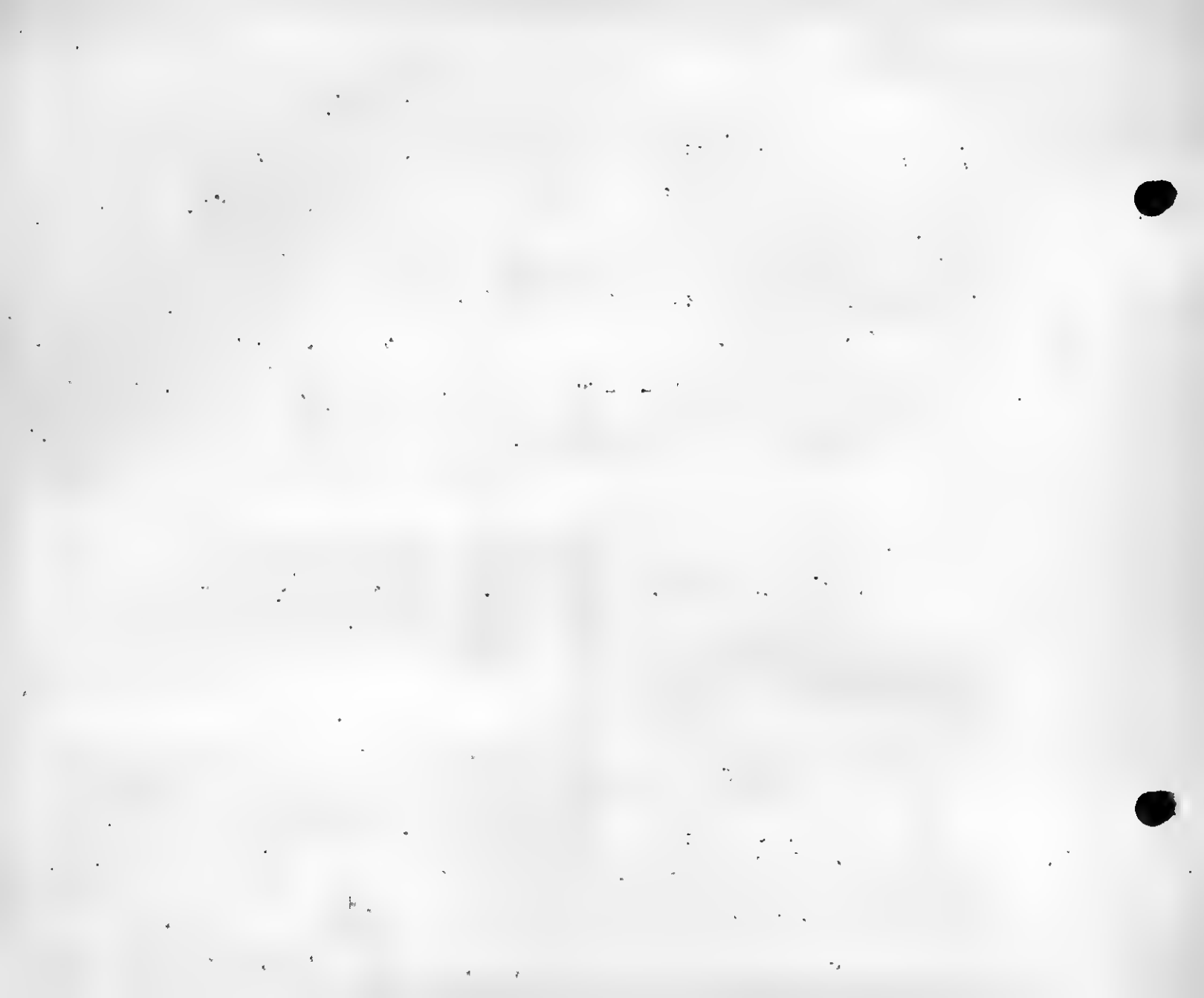
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| | | | | | | | |
|--|--|---|---|--|------------------------------------|--|--|
| 1 DECEASED NAME (Type or print) William D Reese | | | 2a DATE OF DEATH Month April Day 20 Year 1968 | | | 2b HOUR 8:30 AM | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH June 1 - 1901 | | 6 AGE (In years last birthday) 66 YRS. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Carroll | |
| 10 CITY OR TOWN OF DEATH Millers | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b COUNTY Carroll | | 13c CITY OR TOWN Millers | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME First Frances Middle Reese Last | | | 15 MOTHER'S MAIDEN NAME First Cora A. Middle Engleman Last | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO. 214-05-3699 | | 17 INFORMANT Miss Wm Reese Address Millers, Md | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Anteriorly existing Cardiac Vascular Disease | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Dec , 19 47 , to April 20 , 19 68 , that (I) (we) last saw the deceased alive on 4/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE W H Howard M.D. | | | | 22c DATE SIGNED 4/21/68 | | 22d PHYSICIAN'S NAME (Type) W H Foward M.D. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE April 22, 1968 | | 23c NAME OF CEMETERY OR CREMATORY Black Rock Cemetery | | 23d LOCATION (City or Town) (County) (State) Brodbecks, Pa. | |
| 24 FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md. | | | | 25a REC'D BY REGISTRAR APR 23, 1968 | | 25b REGISTRAR'S SIGNATURE William Judge | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 15503 MARYLAND STATE DEPARTMENT OF HEALTH 1555 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|---|--|--|--------------------------------|--------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First Emma | | | Middle Amelia | | | Last Ritter | | | 2a. DATE OF DEATH Month Day Year April 22 1968 | | | 2b. HOUR 330 PM | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH May 8, 1873 | | | 6. AGE (In years last birthday) 94 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Penna | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.AA. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Carroll Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Middleburg | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brookfield Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland | | | 13b. COUNTY Carroll | | | 13c. CITY OR TOWN Taneytown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER East Baltimore Street | | | | | |
| 14. FATHER'S NAME First Middle Last Jacob Waybright | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lucinda Sharretts | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 178-22-9944D | | | 17. INFORMANT Luther Ritter | | | Address Littlestown, Pa. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line—for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>433.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Years</u> | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerotic heart disease</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/10/64</u> , 19 <u> </u> , to <u>Now</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4/21/68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>J.H. Caricofe</u> | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <u>4/22/68</u> | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) J.H. CARICOFE | | | 22e. ADDRESS Union Bridge, Md. 21791 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 4/24/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Keysville Carroll Md. | | | | | | | |
| 24. FUNERAL DIRECTOR C.O. Fuse & Son | | | ADDRESS Taneytown, Md. | | | 25a. REC'D BY REGISTRAR DATE APR 23 1968 | | | 25b. REGISTRAR'S SIGNATURE Michaela Judge | | | | | | | |



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

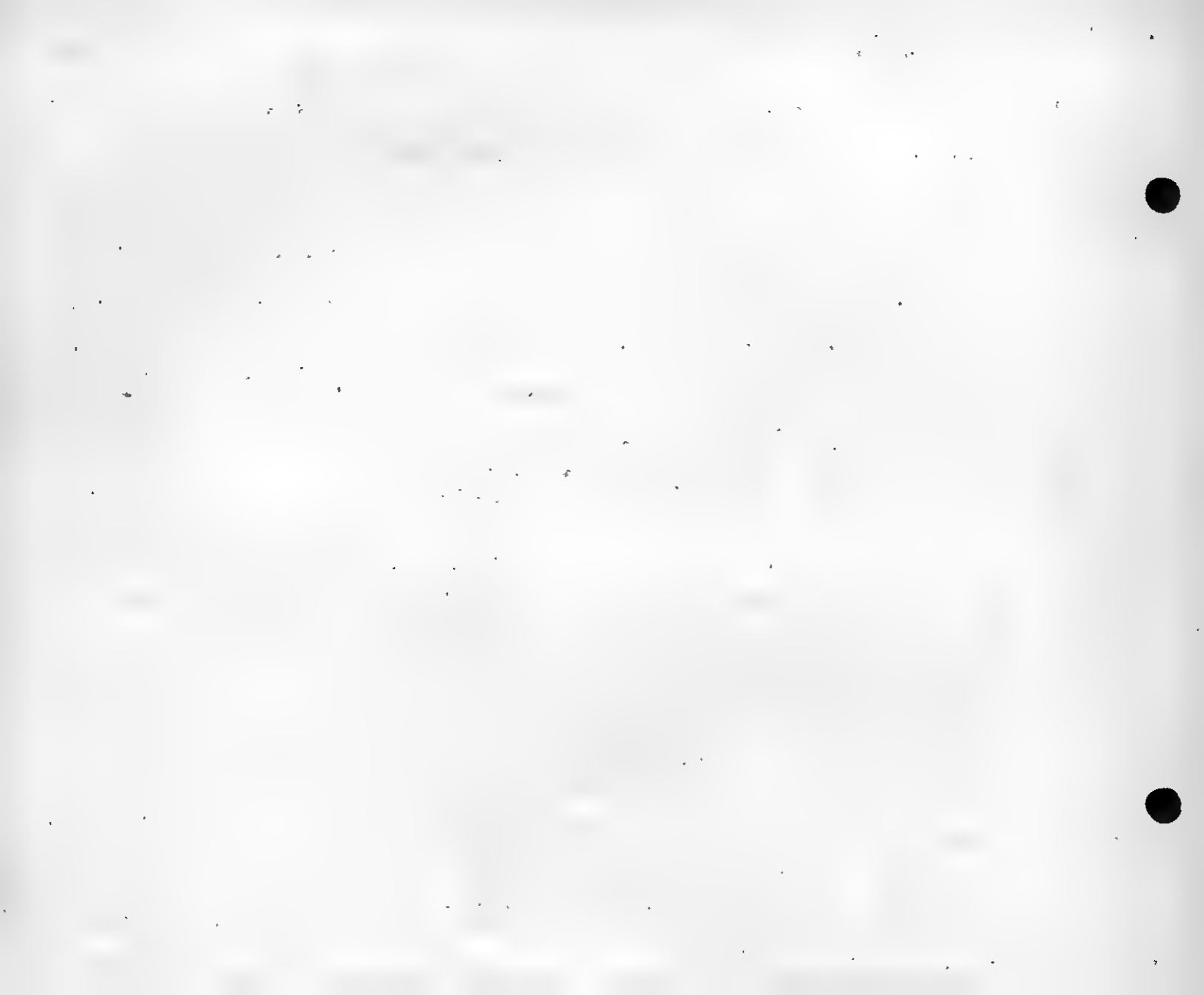
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| | | | | | | | | | | | |
|--|--|---|---|---|------|--|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) PEARL | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year APRIL 10 1968 | | | 2b. HOUR 7:20 P.M. | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH [REDACTED] | | 6. AGE (In years last birthday) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH CARROLL Md. | | | | | |
| 10. CITY OR TOWN OF DEATH SYKESVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRINGFIELD STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED | | | 12b. KIND OF BUSINESS OR INDUSTRY TAILOR SHOP | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER PAUL ST. 12 W. #1 MARYLANDER APT | |
| 14. FATHER'S NAME First Middle Last MORTON XXXXXXXXXX | | | | 15. MOTHER'S MAIDEN NAME First Middle Last SARUBIN XXXXXXXXXX IDA ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO. 215-10-7370-A | | | 17. MORTON SARUBIN, 12 W. READ ST. #1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Asymptomatic DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days unknown 8 months | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Postoperative infection | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-27-68 , 19__, to 4-10-68 , 19__, that (I) (we) last saw the deceased alive on 4-10-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Paul G. Ensor, M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 10 April 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) PAUL G. ENSOR, M.D. | | | | | | 22e. ADDRESS SPRINGFIELD STATE HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 4-12-68 | | | 23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL | | | 23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND | | |
| 24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215 | | | | | | 25a. REC'D BY REGISTRAR DATE APR 15 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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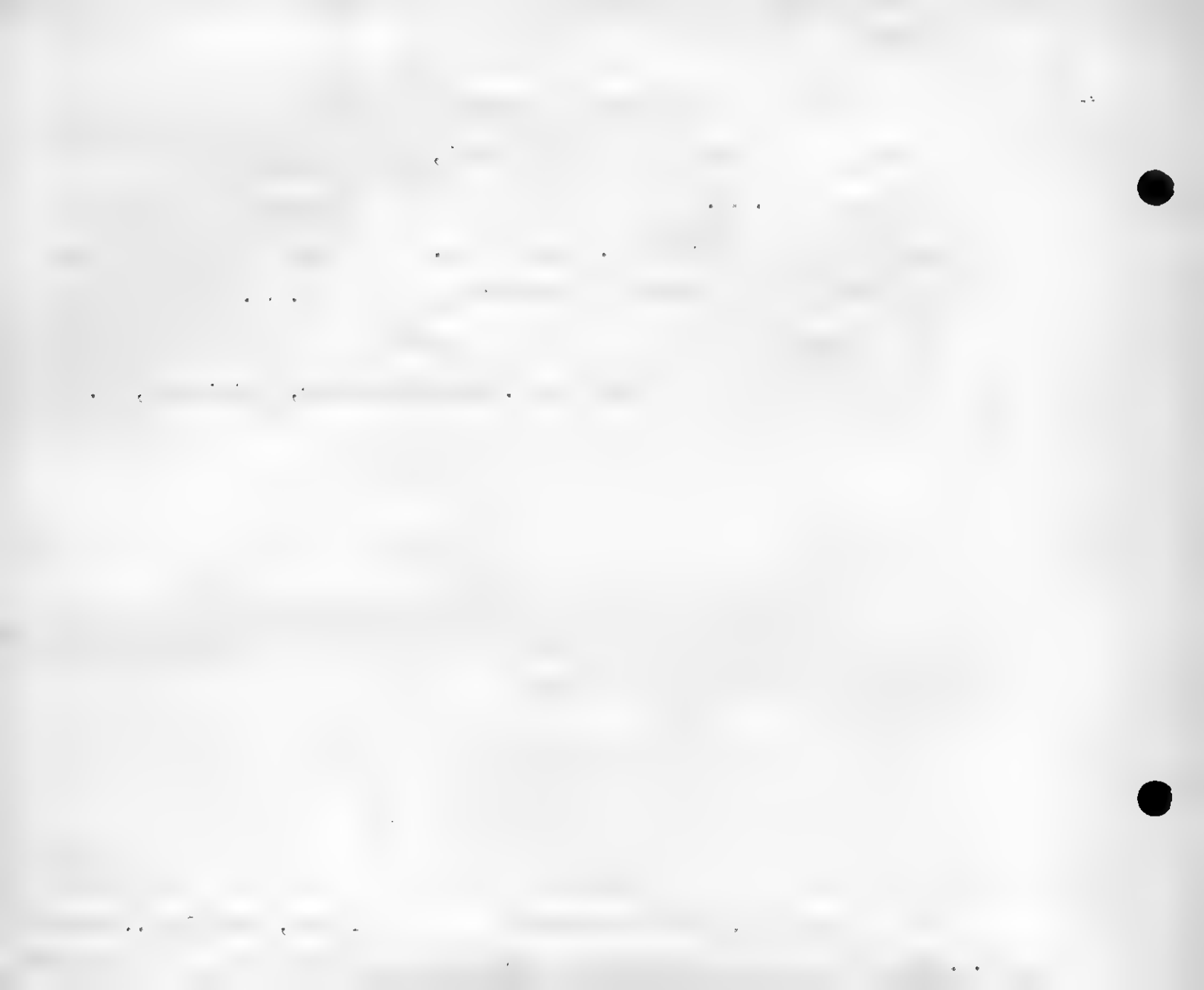
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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05507

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) Ernest Clayton Selby | | | 2a. DATE OF DEATH Month 23 Day 1968 Year 1968 | | | 2b. HOUR 1:10 M | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 1, 1884 | | 6. AGE (In years last birthday) 83 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md | | | | |
| 10. CITY OR TOWN OF DEATH Westminster | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. General Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Westminster | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER R.F.D. #7 | |
| 14. FATHER'S NAME First Middle Last Unknown | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. Carroll Weishaar, Westminster, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 437.4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 23.1 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 10, 1968 , to April 23, 1968 , that (I) (we) last saw the deceased alive on April 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE John S. Harshey, M.D. | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/23/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D. | | 22e. ADDRESS 8 Anchor St. Westminster, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 25, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Baust Cemetery | | 23d. LOCATION (City or Town) (County) (State) Tyrone, Carroll Co., Maryland | | | | |
| 24. FUNERAL DIRECTOR C.O. Fuss & Son | | ADDRESS Taneytown, Maryland | | 25a. REC'D BY REG. STRAR APR 25 1968 | | 25b. REG. STRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--------|--|--|--|-----------------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | |
| Florence | | | Morey | | SOUDER | April, 27, 1968 | | | noon M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | |
| female | | white | | 4-9-1871 | | 97 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7b. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| New Jersey | | U.S.A. | | | | Carroll Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Sykesville | | | Springfield State Hosp. | | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | | Spring | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 11608 Goodloe Rd. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Samuel Morey | | | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| no | | | 213-58-0701-J1 | | | Springfield State Hosp. | | | Sykesville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio-vascular disease.</u> | | | | | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u> | | | | | | | | | | | |
| (b) <u>Advanced generalized arteriosclerosis.</u> | | | | | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| <u>CBS assoc. with cerebral arteriosclerosis.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-8-59</u> , 19 <u> </u> , to <u>4-27-68</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4-27-68</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | | |
| <u>Dr. Antonius Glahn, M.D.</u> | | | | | | 4-27-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Antonius Glahn, M.D. | | | | | | Springfield State Hospital | | Sykesville, Maryland 21784 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| 5/1/68 | | | | Memorial Park | | St. Petersburg, | | Florida | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home 1331 Rockville Pike Rockville, Maryland | | | | | | MAY 01 1968 | | <u>Charles Judge</u> | | | |



CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Anna Mary Stars Field | | | 2a. DATE OF DEATH Month April Day 29 Year 1968 | | | 2b. HOUR 1:10 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Dec 7 - 1887 | | 6. AGE (In years last birthday) 80 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Cornwall Co. Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Cornwall Md. | |
| 10. CITY OR TOWN OF DEATH Manchester | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Reisterstown | | 13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 107 gerard ave | | 14. FATHER'S NAME First Eshverson Middle Durbin Last Bingham | | 15. MOTHER'S MAIDEN NAME First Bingham Middle Reisterstown Last Reisterstown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. 215-54-4660 | | 17. INFORMANT Mrs Margaret Stallings Address 107 gerard ave | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4/29 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cerebral Vascular Disease 2 yrs | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 12/21 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 1968, to 4/29 , 1968, that (I) (we) last saw the deceased alive on 4/29 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W.H. Foard M.D. | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/29/68 | |
| 22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D. | | 22e. ADDRESS Manchester, Md 21102 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 2, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery | | 23d. LOCATION (City or Town) (County) (State) Reisterstown, Md. | |
| 24. FUNERAL DIRECTOR J. F. Eline & Sons | | | | ADDRESS Reisterstown, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 01 1968 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

0550S

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) WALTER SCOTT TAYLOR | | | 2a. DATE OF DEATH Month APRIL Day 21 Year 1968 | | | 2b. HOUR 9A M. | |
| 3. SEX Male | | 4. RACE WHITE | | 5. DATE OF BIRTH Oct 20 1889 | | 6. AGE (In years lost birthday) 78 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll | |
| 10. CITY OR TOWN OF DEATH Pataasco | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridge Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Section HAND | | 12b. KIND OF BUSINESS OR INDUSTRY Rail Road | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Pataasco | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER RD #1 Finksburg P.O. | | 14. FATHER'S NAME First DAVID Middle E Last TAYLOR | | 15. MOTHER'S MAIDEN NAME First LAURA Middle JANE Last BLIZZARD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO. 705-10-4884 | | 17. INFORMANT Marshall Knight | | Address Pataasco MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary HEART Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 3, 1966 to April 21, 1968 , that (I) (we) last saw the deceased alive on March 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph E. Bush MD | | | | 22c. DATE SIGNED April 21, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Joseph E. Bush MD | | | | 22e. ADDRESS NAMPSTEAD MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE APRIL 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEM. | | 23d. LOCATION (City or Town) (County) (State) GAUMER, CARROLL, MD. | |
| 24. FUNERAL DIRECTOR James G. Saffell | | | | 25a. REC'D BY REGISTRAR WESTMINSTER, MD | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Fannie | | First (Grissom) | | Middle NMN | | Last TOWNSEND | | 2a. DATE OF DEATH Month April , Day 14 , Year 1968 | | 2b. HOUR 10 a.m. | |
| 3. SEX female | | 4. RACE Negro | | 5. DATE OF BIRTH 7-11-93 | | 6. AGE (In years last birthday) 74 YRS | | IF UNDER YEAR MONTHS 74 | | IF UNDER 24 HRS. HOURS 10 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Mississippi | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY — | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3902 Bareva Rd., Balto. Md. | | | |
| 14. FATHER'S NAME Allen Townsend - dec. | | First Allen | | Middle Townsend | | Last dec. | | 15. MOTHER'S MAIDEN NAME Peggy Roberts - dec. | | First Peggy | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 578-24-5846 | | 17. INFORMANT Address Springfield State Hospital Records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Paget's disease of the bones CBS Assoc. with cerebral arteriosclerosis with psychosis reaction. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-2-67 , 19__, to 4-14-68 , 19__, that (I) (we) lost saw the deceased alive on 4-14-68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Octavio A. Ruiz M.D. | | 22c. DEGREE M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22d. DATE SIGNED 4-14-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D. | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 4-18-68 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR Morton E. Dyett S.H. 1761 Laurens | | ADDRESS Dyett S.H. 1761 Laurens | | 25a. REC'D BY REGISTRAR DATE APR 17 1968 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

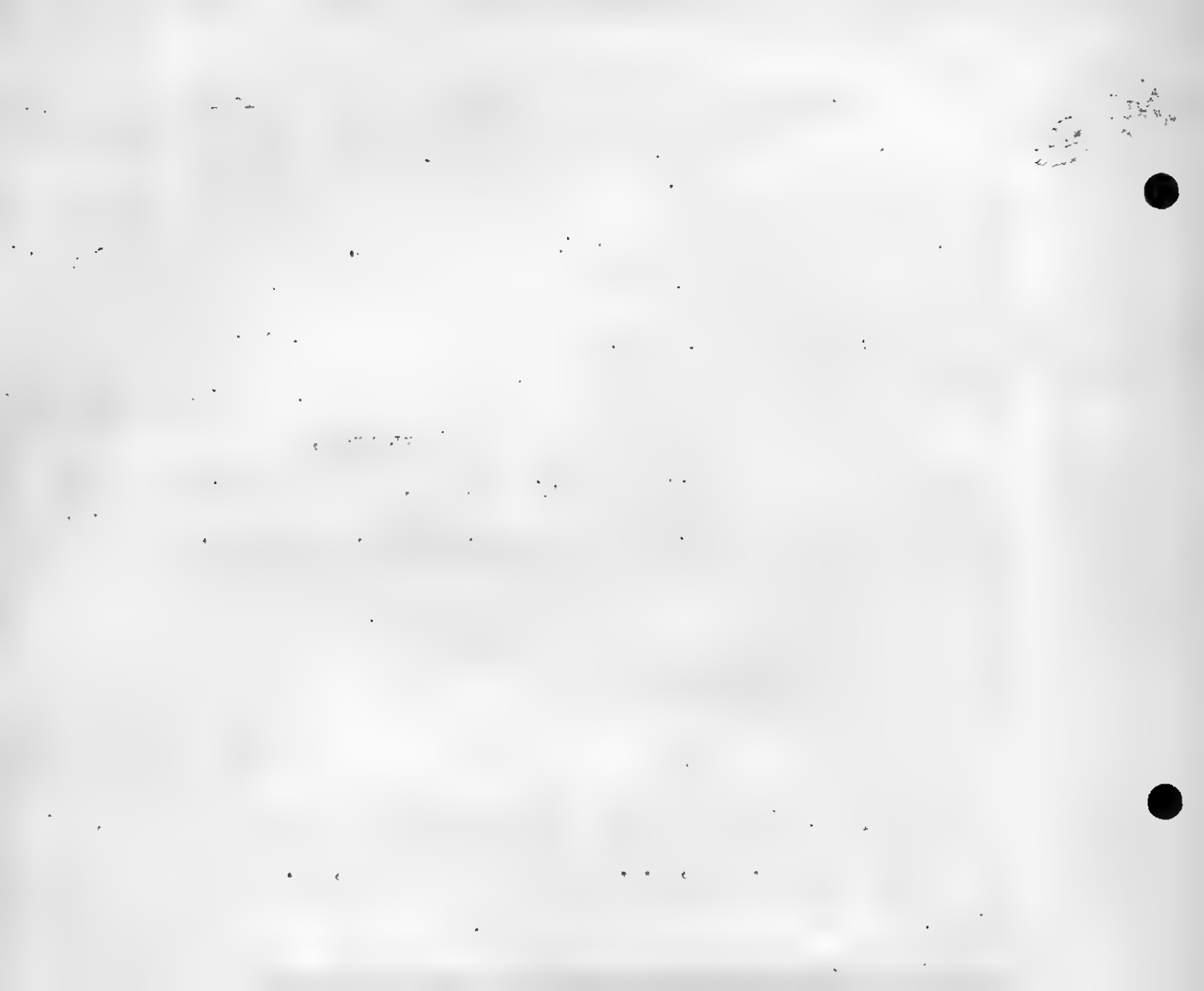
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|--------|---|---|--|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR P M |
| Minnie Lee Tucker | | | | | | 4-30-68 | | | 8:30 |
| 3 SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Female | White | | Oct 31, 1884 | | | 83 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Md. | | | U. S. A. | | | | Carroll Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Gist | | | Klees Mill Road | | | Nurse | | Hospital | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | Carroll | | Sykesville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rt 1 |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Milton Dorsey Hall | | | | | | Anna Estelle Earp | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | - | | Mrs. Estelle Pickett New Windsor, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal and thoracic aneurysm, 4410 DUE TO, OR AS A CONSEQUENCE OF (b) Dissecting with rupture, shock and cardiac DUE TO, OR AS A CONSEQUENCE OF (c) arrest and arteriosclerosis, generalized. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1960 through 4/30/68 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19____, to 4/30/68 , 19____, that (I) (we) last saw the deceased alive on 4/30/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Howard E. Hall | | | 22c. DATE SIGNED May 1, 1968 | | | 22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D. | | | |
| 22e. ADDRESS Sykesville, Md. | | | 22f. ADDRESS Sykesville, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 5-4-68 | | St. Johns Cemetery | | Ellicott City, Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Harry W. Haight | | | DATE MAY 6 1968 | | | Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1 DECEASED-NAME (Type or print) Viola L. Uhler | | First Middle Last | | 2a. DATE OF DEATH Month Day Year April 30 1968 | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 3-6-1902 | | 6. AGE (In years last birthday) 66 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) W. Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | |
| 10. CITY OR TOWN OF DEATH Holbrook | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At Home | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 5317 Cuthbert Avenue | | 14. FATHER'S NAME First Middle Last Robert Lucas | | 15. MOTHER'S MAIDEN NAME First Middle Last Coleman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO NONE | | 17. INFORMANT Address Norris L. Uhler-5317 Cuthbert Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic pyelo-nephritis; uremia 5700 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1000 A.S.H.D.; C.H.F. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-22- , 19 68 , to 4-30 , 19 68 , that (I) (we) last saw the deceased alive on 4-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Barbu Calin | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4-30-68 | |
| 22d. PHYSICIAN'S NAME (Type) DR BARBU CALIN | | 22e. ADDRESS 8811 Liberty Rd. Randallstown | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hgts. Ave | | | | 25a. REC'D BY REGISTRAR DATE MAY 1 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

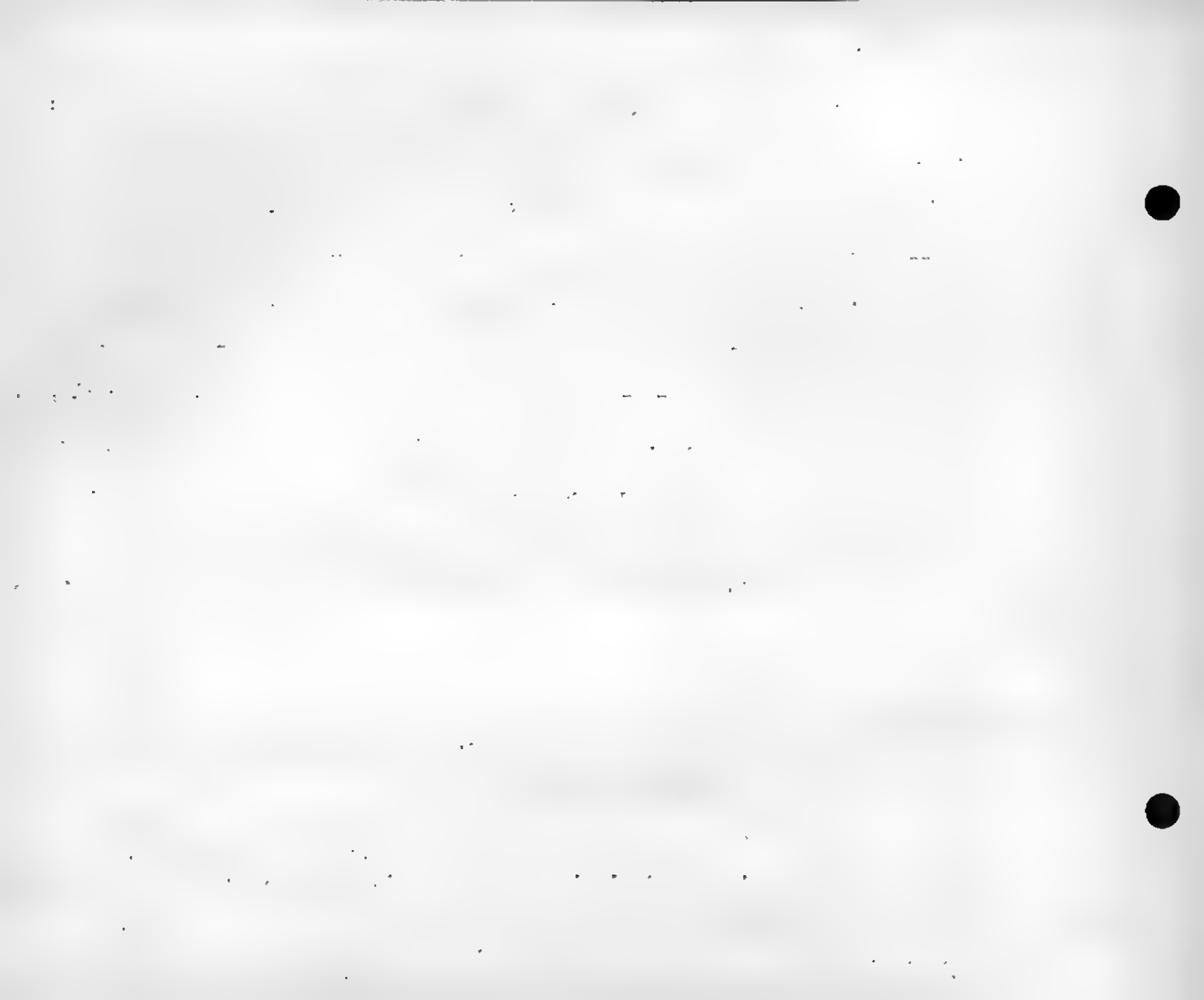
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|--|---------------------------------------|---|--|--|--|--|--|---|-------------------|--------------------|-----------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) Grace | | | First May | | Middle Watson | | Last Watson | | 2a. DATE OF DEATH 4 Month 16 Day 68 Year | 2b. HOUR 2:45 P M | | | |
| 3 SEX female | | 4. RACE white | | 5. DATE OF BIRTH 8/21/83 | | 6. AGE (in years last birthday) 84 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rural--Sykesville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5645 Govans Avenue | | | | | |
| 14. FATHER'S NAME Mortimer | | | First - | | Middle Watson | | Last Watson | | 15. MOTHER'S MAIDEN NAME Susan | | First - | Middle - | Last Yeager |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 220-14-1320-T | | 17. INFORMANT Address Springfield Hospital records, Sykesville, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4231 (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease with psychotic react. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 5/12/ , 19 67 , to 4/16/ , 19 68 , that he (we) last saw the deceased alive on 4/16/ , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Renato R. Espina | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 4/16/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D. | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/19/68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. | | | | | | ADDRESS 6009 Harford Rd.-Balto., Md. 21214 | | 25a. REC'D BY REGISTRAR DATE APR 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5518

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

5515

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|--|--|
| 1 DECEASED-NAME (Type or print) John Blynn Welden | | | 2a. DATE OF DEATH April Month 1 1968 | | | 2b. HOUR 9:00 AM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 3/1/93 | | 6. AGE (In years last birthday) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Carroll County, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) (retired) ENGINEER | | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 10401 Grosvenor Place | | |
| 14. FATHER'S NAME First Middle Last John CALVIN Welden | | | 15. MOTHER'S MAIDEN NAME First Middle Last Agnes Baker | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) None | | | 16b. SOCIAL SECURITY NO. 579-09-2943-A | | 17. INFORMANT Address Records, Springfield State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>thrombosis of left coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>bilateral bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours or days hours or days days | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/2/67</u> , 19__, to <u>4/1/68</u> , 19__, that (I) (we) lost the deceased alive on <u>4/1/68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Octavio A. Ruiz</u> | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 4/2/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D. | | | | | | 22e. ADDRESS Springfield State Hospital Sykesville, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 4/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN MAUSOLEUM | | | 23d. LOCATION (City or Town) (County) (State) BLADENSBURG, M.D. | | | |
| 24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WISCONSIN AVE, ADDRESS WASHINGTON, D.C. | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

VR 1515-1
30M REV 1/68



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340-1341-1342-1343-1344-1345-1346-1347-1348-1349-1350-1351-1352-1353-1354-1355-1356-1357-1358-1359-1360-1361-1362-1363-1364-1365-1366-1367-1368-1369-1370-1371-1372-1373-1374-1375-1376-1377-1378-1379-1380-1381-1382-1383-1384-1385-1386-1387-1388-1389-1390-1391-1392-1393-1394-1395-1396-1397-1398-1399-1400-1401-1402-1403-1404-1405-1406-1407-1408-1409-1410-1411-1412-1413-1414-1415-1416-1417-1418-1419-1420-1421-1422-1423-1424-1425-1426-1427-1428-1429-1430-1431-1432-1433-1434-1435-1436-1437-1438-1439-1440-1441-1442-1443-1444-1445-1446-1447-1448-1449-1450-1451-1452-1453-1454-1455-1456-1457-1458-1459-1460-1461-1462-1463-1464-1465-1466-1467-1468-1469-1470-1471-1472-1473-1474-1475-1476-1477-1478-1479-1480-1481-1482-1483-1484-1485-1486-1487-1488-1489-1490-1491-1492-1493-1494-1495-1496-1497-1498-1499-1500-1501-1502-1503-1504-1505-1506-1507-1508-1509-1510-1511-1512-1513-1514-1515-1516-1517-1518-1519-1520-1521-1522-1523-1524-1525-1526-1527-1528-1529-1530-1531-1532-1533-1534-1535-1536-1537-1538-1539-1540-1541-1542-1543-1544-1545-1546-1547-1548-1549-1550-1551-1552-1553-1554-1555-1556-1557-1558-1559-1560-1561-1562-1563-1564-1565-1566-1567-1568-1569-1570-1571-1572-1573-1574-1575-1576-1577-1578-1579-1580-1581-1582-1583-1584-1585-1586-1587-1588-1589-1590-1591-1592-1593-1594-1595-1596-1597-1598-1599-1600-1601-1602-1603-1604-1605-1606-1607-1608-1609-1610-1611-1612-1613-1614-1615-1616-1617-1618-1619-1620-1621-1622-1623-1624-1625-1626-1627-1628-1629-1630-1631-1632-1633-1634-1635-1636-1637-1638-1639-1640-1641-1642-1643-1644-1645-1646-1647-1648-1649-1650-1651-1652-1653-1654-1655-1656-1657-1658-1659-1660-1661-1662-1663-1664-1665-1666-1667-1668-1669-1670-1671-1672-1673-1674-1675-1676-1677-1678-1679-1680-1681-1682-1683-1684-1685-1686-1687-1688-1689-1690-1691-1692-1693-1694-1695-1696-1697-1698-1699-1700-1701-1702-1703-1704-1705-1706-1707-1708-1709-1710-1711-1712-1713-1714-1715-1716-1717-1718-1719-1720-1721-1722-1723-1724-1725-1726-1727-1728-1729-1730-1731-1732-1733-1734-1735-1736-1737-1738-1739-1740-1741-1742-1743-1744-1745-1746-1747-1748-1749-1750-1751-1752-1753-1754-1755-1756-1757-1758-1759-1760-1761-1762-1763-1764-1765-1766-1767-1768-1769-1770-1771-1772-1773-1774-1775-1776-1777-1778-1779-1780-1781-1782-1783-1784-1785-1786-1787-1788-1789-1790-1791-1792-1793-1794-1795-1796-1797-1798-1799-1800-1801-1802-1803-1804-1805-1806-1807-1808-1809-1810-1811-1812-1813-1814-1815-1816-1817-1818-1819-1820-1821-1822-1823-1824-1825-1826-1827-1828-1829-1830-1831-1832-1833-1834-1835-1836-1837-1838-1839-1840-1841-1842-1843-1844-1845-1846-1847-1848-1849-1850-1851-1852-1853-1854-1855-1856-1857-1858-1859-1860-1861-1862-1863-1864-1865-1866-1867-1868-1869-1870-1871-1872-1873-1874-1875-1876-1877-1878-1879-1880-1881-1882-1883-1884-1885-1886-1887-1888-1889-1890-1891-1892-1893-1894-1895-1896-1897-1898-1899-1900-1901-1902-1903-1904-1905-1906-1907-1908-1909-1910-1911-1912-1913-1914-1915-1916-1917-1918-1919-1920-1921-1922-1923-1924-1925-1926-1927-1928-1929-1930-1931-1932-1933-1934-1935-1936-1937-1938-1939-1940-1941-1942-1943-1944-1945-1946-1947-1948-1949-1950-1951-1952-1953-1954-1955-1956-1957-1958-1959-1960-1961-1962-1963-1964-1965-1966-1967-1968-1969-1970-1971-1972-1973-1974-1975-1976-1977-1978-1979-1980-1981-1982-1983-1984-1985-1986-1987-1988-1989-1990-1991-1992-1993-1994-1995-1996-1997-1998-1999-2000-2001-2002-2003-2004-2005-2006-2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-2567-2568-2569-2570-2571-2572-2573-2574-2575-2576-2577-2578-2579-2580-2581-2582-2583-2584-2585-2586-2587-2588-2589-2590-2591-2592-2593-2594-2595-2596-2597-2598-2599-2600-2601-2602-2603-2604-2605-2606-2607-2608-2609-2610-2611-2612-2613-2614-2615-2616-2617-2618-2619-2620-2621-2622-2623-2624-2625-2626-2627-2628-2629-2630-2631-2632-2633-2634-2635-2636-2637-2638-2639-2640-2641-2642-2643-2644-2645-2646-2647-2648-2649-2650-2651-2652-2653-2654-2655-2656-2657-2658-2659-2660-2661-2662-2663-2664-2665-2666-2667-2668-2669-2670-2671-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First CHARLOTTE | | | Middle JANE | | | Last WILT | | |
| 2a. DATE OF DEATH | | | Month APRIL | | | Day 19 | | | Year 1968 | | |
| 2b. HOUR | | | A 1:00 | | | M M | | | | | |
| 3. SEX | | | Female | | | 4. RACE | | | White | | |
| 5. DATE OF BIRTH | | | 2-20-1886 | | | 6. AGE (In years last birthday) | | | 82 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? | | | U.S.A. | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Carroll | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | Sykesville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | Springfield State Hospital | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | None | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE | | | Maryland | | | 13b. COUNTY | | | Garrett | | |
| 13c. CITY OR TOWN | | | Grantsville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME | | | First Stephen | | | Middle Wilt | | | Last Rhoda | | |
| 15. MOTHER'S MAIDEN NAME | | | First Rhoda | | | Middle Broadwater | | | Last Broadwater | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | No | | | 16b. SOCIAL SECURITY NO. | | | 220-54-6036 | | |
| 17. INFORMANT | | | Address | | | Records, Springfield State Hospital | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> | | | | | | | | | | Day | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | | | | Years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Generalized arteriosclerosis</u> | | | | | | | | | | Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) | | | | | | | | | | | |
| <u>Mental deficiency, familial or hereditary, severe</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-12-45</u> , 19____, to <u>4-19-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>4-19-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) | | | Antonius Glahn, M.D. | | | 22e. ADDRESS | | | Springfield State Hospital Sykesville, Maryland 21284 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 4/21/68 | | | Robt. Broadwater | | | Swanton Md. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| E. F. Breal | | | Westernport, Md. | | | DATE | | | APR 22 1968 R. Charles Judge | | |



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